

Medical Pluralism and HIV/AIDS in South Africa: What are the barriers to collaboration between Traditional Healers and Medical Doctors?

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This research report was submitted to the Faculty of Humanities, as partial fulfillment for the degree of MA in Health Sociology by Coursework and Research

Johannesburg, 2010

DECLARATION

I, Aviva Tugendhaft (Student No. 0409355J) hereby declare that this report is my own work. It is being submitted for the degree of Masters in Health Sociology at the University of the Witwatersrand, Johannesburg. It has not been submitted previously for any degree or examination at this or any other University.

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ACKNOWLEDGEMENT

I would like to acknowledge the following:

My supervisor, Professor Leah Gilbert, who provided insight, mentorship and continual support throughout the duration of this research project.

Khanyisile Msimang who assisted me in initiating contact with many of the Traditional Healers.

All the participants who agreed to be part of this study.

LIST OF ABBREVIATIONS

HIV	Human Immunodeficiency Virus
AIDS	Acquired Immune Deficiency Syndrome
TH	Traditional Healer
TM	Traditional Medicine
WHO	World Health Organisation
UNAIDS	The Joint United Nations Programme on HIV/AIDS
PSE	Psycho-Social, Environmental
CAM	Complementary and Alternative Medicine
ALP	Aids Law Project
ANC	African National Congress
DOH	Department of Health
NSP	HIV & AIDS &STI National Strategic Plan for South Africa
STI	Sexually Transmitted Infection
MD	Medical Doctor
KI	Key Informant
KZN	Kwazulu-Natal

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INTRODUCTION

In the context of both an allopathic and Traditional Medical system operating in South Africa and the severity of the AIDS epidemic it is necessary to explore options of collaboration that may lead to effective intervention strategies. The concept of collaboration is a complex one. It can mean practicing side by side with some level of recognition, various degrees of collaboration or full integration of Traditional Medicine into all aspects of health care (WHO, 2002). This study therefore aims to gain a more nuanced insight into the complexity associated with it by investigating the obstacles that need to be overcome, as well as the enabling factors that will facilitate the operation of the different paradigms within a collaborative environment, the nature of which will be further explored.

The HIV/AIDS epidemic constitutes a severe threat to Sub-Saharan Africa. Whilst health issues are an obvious result of the epidemic, its effect is far reaching and devastating. The rapid growth of HIV/AIDS is not only hampering development but also reversing previous developmental gains. Furthermore, the epidemic is claiming millions of lives, increasing social and economic inequalities and undermining security of the most vulnerable members of society (Gilbert, Selikow and Walker, 2002). Among the countries in the Sub-Saharan region, South Africa ranks first in terms of the largest number of HIV/AIDS infections. In fact, South Africa's HIV/AIDS statistic is highest on a global scale. The numbers have increased from 2.8 million people in 1997 to 3.5 million in 1999, to 4.7 million in 2000 and now stand at 5.7 million people (UNAIDS, 2008). The rapid spread of the epidemic has no doubt been accelerated by the specific cultural, social, political and economic dynamics of the disease that have interrelated with one another. While South African society is very conducive to the spread of HIV, it is also particularly vulnerable to the impact of the epidemic and the effects have therefore been far-reaching and extremely detrimental (Pelser, 2002; Gilbert, Selikow and Walker, 2010).

In light of the above, it is evident that while responding to the challenge posed by the epidemic undoubtedly constitutes a difficult task, an adequate comprehensive intervention strategy is necessary if present and future impacts of the epidemic are to be mitigated. Indeed, South Africa's response has developed from its initial focus on

purely biological and behavioural factors in the early 1980s to an incorporation of socioeconomic and environmental factors. The fact that the epidemic has managed to reach this high level clearly indicates that such responses have been, for the most part, inadequate and often counterproductive (Natrass, 2007). In order to reach as many people as possible throughout the disease trajectory from prevention, treatment and care, South Africa needed to mobilize all its available social, health and medical resources. However, it seems that in the context of already overburdened health care services, it failed to do so (Squire, 2007).

One of the reasons for this can be seen in that intervention strategies have not fully taken into account the various medical and health care systems operating in South Africa. Traditional Medicine (TM) has existed for a long time in South Africa. It is estimated that over 80% of the population makes use of Traditional Healers (THs) (Cook, 2009: 264). They are often the first line of contact for patients after which many continue to consult these practitioners in addition to, or instead of, medical doctors (UNAIDS, 2006). Since the late 1970s many have advocated the incorporation of TM within formal health programmes (UNAIDS, 2000). This position has gained popularity in recent years with the recognition of the need to incorporate a psychosocial environmental model within the biomedical understanding of disease and illness and to support medical and health care pluralism (Gilbert & Gilbert, 2004)

The idea of collaboration between different health care systems, in this case the African Traditional health care system with the allopathic, is therefore hardly new but has had limited success so far. South Africa, in particular is behind other African countries in its recognition and establishment of TM (Richter, 2003). This type of collaboration however could potentially serve as an effective intervention strategy in light of the magnitude of the HIV/AIDS epidemic and due to fact that the population most affected by HIV/AIDS, that being the African population, is the one in which a large percentage of the people consult THs. Firstly, collaboration could provide a means of greater support, cooperation and education needed by the THs and secondly, would enable the formal health care system to expand its reach and efficacy of its prevention and treatment programmes (Richter, 2003). Furthermore, because of the critical role THs play in African societies they are not likely to disappear anytime soon. They survived the colonial and apartheid legacies forbidding their practice and

continue to play a fundamental role in addressing many of the psychosocial problems encountered by members of their communities (UNAIDS, 2000). With this in mind, it seems obvious that an effective collaborative strategy should be developed. Other African countries, such as Guinea (UNAIDS, 2000), have been successful in this regard and have effectively incorporated TM within the formal health care system. The obstacles that are preventing this from occurring in South Africa must therefore be fully explored and better understood. To date, the literature on this topic is scant and inadequate. The full complexity of the issues involved has not been interrogated and actual assessments of the obstacles have not been conducted.

This study therefore examines this complexity in the context of HIV/AIDS in order to determine what the obstacles are that are hindering collaboration between THs and medical doctors. Three areas are explored:

- The knowledge, attitudes, beliefs and practices (including prevention and treatment) of THs surrounding HIV/AIDS and the perception towards the biomedical realm
- The perception, attitudes and policies of the biomedical/allopathic establishment as well as
- The government's position towards TM and its practitioners.

While many notions exist concerning the obstacles to collaboration, many of these are based primarily on misconceptions about beliefs on behalf of THs with regard to HIV/AIDS and the vast differences between the two health care systems. However, many of these explanations rely on evidence that is outdated. African Traditional Medicine is not a stagnant system but one that adapts to the social environment in which it is located (UNAIDS, 2006). Many of the views, therefore, that previously existed with regard to HIV/AIDS are no longer prevalent and prevention and treatment strategies have been improved (some of which are as of the result of collaborative efforts). These include increase in recommendation of condom use as well as referral to clinics and advocacy of ARV treatment (Wreford and Esser, 2008:). With this in mind, it is relevant to understand what the position is on behalf of THs today, and how they integrate biomedical concepts into their traditional belief system and methods of practice, and whether this hinders or has the potential to facilitate collaboration between the two health care systems. Furthermore, the failure of collaborative efforts has often been blamed primarily upon the traditional medical

realm and the existence of unscrupulous practitioners (Richter, 2003). It is therefore essential to investigate the role that others are playing in facilitating or preventing collaboration. The position on behalf of government as well as the medical establishment with regard to TM must be assessed in order to develop a holistic and more nuanced understanding of the obstacles that exist in this regard.

LITERATURE REVIEW

HIV/AIDS

South Africa is the country that has been hardest hit by the AIDS epidemic. The HIV/AIDS numbers within the country are the highest on a global scale, recently estimated to have reached 5.7 million people (UNAIDS, 2008). While there exist many underling causes of the rapid spread of the disease, this high prevalence rate cannot be completely understood without determining the key social factors which have, undoubtedly, shaped the way in which the epidemic has unfolded in South Africa.

Firstly, the social changes brought about by colonialism and apartheid severely affected the way the HIV/AIDS epidemic unfolded. These changes included a replacement of traditional values with western Christian ideals as well as the development of a migrant labour system. The former evidently affected the way in which sexual matters were viewed and expressed. Sex became a taboo topic and the openness that had previously existed around discussions of sex, including regulatory measures, perished (Delius and Glaser, 2002). This undoubtedly facilitated the spread of HIV/AIDS, as the youth were no longer provided with accurate information and education on sexual matters.

With the implementation of the migrant labour system social cohesion was disrupted and the increase in mobility allowed for a conducive environment for the spread of sexually transmitted infections (STIs) including HIV/AIDS. This economic system removed numbers of sexually active young men temporarily from the countryside to work in the mines (Hunter, 2007). These men were exposed to dire conditions within the hostels (including overcrowding and lack of cleanliness), which made them susceptible to disease, and as more time was spent away from the family more men began to find substitute sexual partners (Rose-Innes, 2006). When these men returned

to the rural areas they brought with them the sexual diseases they had contracted and in this way the spread of such diseases was facilitated (Jochelson, 2001).

THs, as guardians of traditional values, could potentially play a fundamental role in reestablishing both social cohesion as well as an openness towards discussions of sexual issues. In this way THs may serve as an essential component in addressing the epidemic and this study therefore explores this potential.

Another factor which is important in understanding the way in which the HIV/AIDS epidemic has unfolded is the erosion of social capital. Although 'social capital' is not an easily definable phrase (Gilbert and Walker, 2002) the social capital approach suggests that people are more likely to partake in and promote health-enhancing activities if they are part of a community that offers high levels of participation in local networks and organizations which are characterized by high levels of trust, reciprocal help and support and a positive local community identity. This approach argues that the most important element that determines whether people will participate in health promoting activities is if they perceive themselves to have "citizen power" (Campbell, 2003). This refers to an acknowledgement of and regard for the views expressed within communities as well as a forum that enables community participation in important decision-making processes with regard to the family, school and neighbourhood. Therefore, the social capital standpoint focuses on two areas. The one is the social cohesion and interconnectedness within the community itself- a sense of belonging to a community where high levels of participation and trust exist. The other is a sense of connection in an even broader context. This refers to an involvement, as active citizens, in decisions that will impact directly on the community. The latter affects health promoting behaviour because when individuals feel they are in control of the important things in their lives they will seek to enhance such control (ibid). However, when perceived lack of power and control in these important areas exists there will be no motivation to regulate activities whose consequences will only be felt in the future.

It is evident that colonialism and, later, apartheid eroded both social cohesion as well as citizen power. Under both these systems Africans were denied civic rights and rules and regulations were merely imposed upon them. Furthermore, it has been shown above that communities were broken apart due to reallocation of land and the

migrant labour system. While African tradition relied on inter-communal support and cohesion, colonialism and apartheid transformed this community-based culture into an individualistic culture whereby concerns for others, and the future, perished and in this way an environment conducive to the spread of STDs and HIV/AIDS flourished and Africans became the primary group affected by the epidemic.

THs can be considered as a component of social capital as they are part of the social networks within African communities and play an important and influential role in these communities. As discussed above, THs could play an important role in fostering social cohesion, which in turn may strengthen health-promoting activities. This area is considered in the study.

Poverty is a further factor that has shaped the way in which the HIV/AIDS epidemic has unfolded in South Africa and has contributed to the uneven affect of the epidemic on the population. While it has been estimated that 44% of South Africans live in poverty, 95% of this statistic is African and 5.3% is female (Gilbert and Walker, 2002). It is therefore evident that African women occupy the most vulnerable positions, as they are the poorest. The effects of poverty are far reaching and these, in turn, have shaped the way in which the epidemic has developed. Firstly, the living conditions of most poverty stricken individuals is characterized by overcrowding (often in informal settlements) due to inadequate government housing policies, inadequate sanitation and lack of safe drinking water (Ankrah, 1991). These conditions create an environment that is extremely susceptible to the spread of HIV/AIDS and individuals living in such conditions become extremely vulnerable to the impact of the disease. This is further exacerbated by the systematic inequalities present in the health care system (Gilbert and Walker, 2002). While these individuals cannot afford private health care facilities, the public health facilities offered are often inadequate. This is, in part, due to the fact that the portion of South Africa's GDP allocated for health care is distributed unevenly. In fact, 60% of these funds are used to pay for the healthcare of those with private medical insurance (Marais, 2006). The result is that those who are most in need of HIV treatment are often denied it or receive insufficient treatment, which ultimately contributes to the impact of the epidemic on these marginalized individuals.

The inadequate health services provided have placed additional strain on African women who are expected to compensate for such services. This is due to the fact that social constructions have made women responsible for reproductive labour (Ankrah, 1991: 968). The burden of caring for the sick and dying is therefore placed upon women, which in turn hampers their development and locks them further into poverty. This has undoubtedly shaped the way in which HIV/AIDS has had a greater impact on women (Gilbert & Selikow, 2009)

Furthermore, social factors such as gender inequality and sexual violence have further contributed to the way in which HIV/AIDS has disproportionately affected African women in South Africa (Rose-Innes, 2006). Many African cultures encompass a vision of women as minors or, at least, as inferior to men (O' Grady, 2004). Many cultures prevent women from owning land or cattle. These cultural constraints as well as the 'imprisonment' of women in reproductive labour, as discussed above, has led to economic and social dependency of women on men (Ankrah, 1991; Gilbert & Selikow, 2009). This has constrained the ability of women to deny unsafe sexual practices with their partners, as there exists a fear of being abandoned and no longer provided for. Furthermore, sexual violence, which has become an accepted norm in many communities, and which is further exasperated by cultural ideals which promote multiple sexual partners, contributes to the vulnerability of women and their inability to negotiate sexual relations or demand the use of condoms (Gilbert and Walker, 2002; Gilbert & Selikow, 2009).

THs offer an environment for both men and women within the African communities to discuss issues of sexual practice and therefore may be effective in firstly empowering women, even if only in a psychological manner, and addressing the behaviour of promiscuous males. In addition, THs may be playing an important role in the promotion of condom use, which would address many of the problems discussed above, and this is further explored in the study.

Stigma is another factor which has played a significant role in shaping the way in which the epidemic has unfolded in South Africa. Since the initial outburst of the HIV/AIDS epidemic people infected were viewed as deviant and as possessing an undesirable difference. In this way the blame was placed upon the victim. Initially this blame was placed upon white homosexual males (Phillips, 2002). They were viewed

as immoral and deviant members of society who partook in unacceptable sexual practices. From the late 1980s when HIV/AIDS became prevalent among, primarily, heterosexual Africans white racism was employed in order to place blame among these 'promiscuous' Africans. HIV/AIDS came to be viewed as a behavioural problem resulting from certain African sanctioned practices (Packard and Epstein, 1992: 352). It is evident therefore that stigma was employed in order to justify a superior status within already existing structures of inequality. This technique, of stigmatization, allows for reassurance as it allows those who construct this idea to draw a distinction between themselves and those infected, it removes any responsibility to the infected as it claims that those who have become infected are guilty i.e. they have acted incorrectly and are therefore being, justifiably, punished. This idea has been further exasperated by cultural ideas surrounding the belief that HIV/AIDS is caused by supernatural forces as punishment for immorality or excessive sexual behaviour (Goldin, 1994; Gilbert & Walker, 2009)

Furthermore, HIV/AIDS has seen the development of self-stigmatization (Parker and Aggleton, 2003). Many infected by the virus attempt to conceal their positive status or merely avoid being tested. This is because they experience a considerable amount of shame emanating from the fact that they do in fact view themselves as morally inferior. Concealment may also arise from a fear of being discriminated against, be it by individuals or the community. In South Africa our legal framework in conjunction with the Bill of Rights serves to prevent discrimination against people living with HIV/AIDS however the reality is very different. Discrimination resulting from the stigmatization of individuals infected with the virus continues to occur. Workers, although supposedly protected, often lose their jobs as a result of disclosure of their HIV status (Cameron, 2005) and there have been incidences of people being brutally killed after disclosing their HIV status. The choice of secrecy on behalf of those infected is preventing access to adequate treatment and undermines strategies aimed at preventing HIV transmission. Many will rather die in silence than admit to being HIV positive. THs could potentially address this secrecy as they may offer an environment whereby patients feel comfortable disclosing their status. This study explores this area.

In light of the above it is evident that HIV/AIDS demands an intervention strategy that focuses on a number of factors and incorporates different role players. Sexual

behaviour has been the primary target of HIV/AIDS prevention strategies (UNAIDS, 2000). Most of these strategies have relied on providing correct information to individuals about HIV transmission and prevention and have been informed and dominated by the biomedical model of disease (UNAIDS, 2006). More recently however sociocultural factors have been considered as sexual behaviour has come to be understood as embedded in social and cultural relationships as well as influenced by environmental and economic processes (UNAIDS, 2000). In order to address these underlying factors mobilization of all available resources needs to occur in order to prevent further spread of HIV/AIDS and to adequately address the needs of those already infected. THs, as the custodians of 'culture' and leaders in their communities have the potential to play a fundamental role in this regard and could be incorporated in prevention and treatment strategies. As indicated earlier, this study further investigates this possibility.

A Sociological Perspective of Health and Illness

The biomedical model of health and illness has dominated medical thought, research and practice since the mid nineteenth century. Today this model continues to govern the medical realm however, since the late twentieth century increasing criticism has been leveled at such an approach and emphasis has been placed on the need for greater recognition of a psychosocial environmental approach to health and illness (Gilbert, Selikow and Walker, 2002). This is related to the changing patterns of disease from 'acute to chronic' and the changing role of medicine from 'cure to care' and management of disease as well as a shift in understanding of the causation of disease from single-causal to multi-causal (ibid). This understanding of the causation of disease relies on multiple factors within the individual as well as within his broader social environment and the relationship between these factors. While the psychosocial environmental model explains the interdependent nature of these different factors, the biomedical model cannot simply be disregarded but rather, an understanding of both is necessary in order to assess disease and the role of different health systems in combating it. This study therefore takes into account the role of both allopathic practitioners as well as that of THs, as operating with the PSE model, and considers the possibility of collaboration between the two.

The Biomedical Model

The biomedical model asserted its autonomy in the mid 19th century during the era of the Scientific Revolution. During this period, due to scientific and technological advancement, medicine was established as a science and was therefore assigned greater power and authenticity upon which individuals came to rely. Power was developed by, but also conferred upon, doctors to define illness and the appropriate methods of treatment. The definition of illness, and treatment, was therefore developed within a biomedical model, the credence of which was supported by health professionals as well as patients seeking support.

The biomedical model is therefore a scientific model but must be fully understood by an exploration of its components namely, the nature and cause of health and illness, the appropriate intervention methods, the role of the patient during treatment (Gilbert, Selikow and Walker, 2002) and the impact of the illness on the patient (Armstrong, 2000).

The starting point for the biomedical approach is the assumption that disease or illness can be reduced to a pathological lesion and that in order to address the illness it is therefore necessary to identify and treat the lesion (Armstrong, 2000:). In order to accomplish this said objective the biomedical approach relies upon the 'doctrine of specific aetiology' (Dubos, 1992) whereby each lesion is believed to have a specific underlying cause that is biological in nature (otherwise known as the germ theory of disease) (Armstrong, 2000). In order to uncover the specific biological cause the biomedical model relies partly on patients' accounts of physical symptoms and mostly on clinical testing and examination. The patient's body is therefore viewed as a machine that must be clinically examined and treated by either removing the lesion or reducing the negative effects by prescribing the appropriate medication (Armstrong, 2000). The patient is therefore passive during the treatment phase and the success of such treatment is in no way accredited to any psychological position, action or behaviour of the patient outside of his administration of the prescribed medication. In terms of the consequence and effect of the illness on the patient, the biomedical approach simply considers the individual biological changes that occur in the patient and does not take into account the effect the illness has on the patient's social status and role (Armstrong, 2000).

In terms of the efficacy of specific medications, the biomedical model assesses such according to scientific standards. This biomedical assessment of efficacy is inextricably linked to theories of knowledge, as described by various authors. Foucault shows how the power of health professionals is linked to knowledge whereby they are able to define 'health' 'disease' and 'medicine' as they possess medical knowledge that the ordinary man does not and this knowledge is seen as absolute (Turner, 1995). Wilber (1998: 56) expresses similar sentiments and refers to "the mechanical paradigm as a flatland whereby spheres of knowledge of indigenous thought are flattened by science through the empirical process". In this way knowledge is only valid in so far as it is objective and can be assessed in empirical terms. In terms of evaluating efficacy of treatment this therefore rests on bioscientific evidence. The biomedical model of health and disease is essentially based upon reductionist science and therefore efficacy of treatment methods is based mainly upon the randomized controlled clinical trial. According to this position, alternative medicine does not exist as there is only room for scientifically proven, evidence-based medicine supported by solid data (Coulter, 2004). Any complimentary or alternative treatments would only be viewed as valid if they were subject to scientific standards of testing. However, as Coulter expresses "To claim that CAM must become evidence-based...is to make an epistemological claim, a preference for one form of knowledge over another. It is also a claim for the dominance of the epistemological basis of orthodox medicine: (2004: 109). This is essentially linked to Foucault's understanding of the power held by health professionals due to the acceptance of one form of knowledge over another. This results in the valuing of biomedical forms of evidence of the nature of health and disease, and the treatment of such, over other forms and signifies the dominance of a western construct of reality.

Furthermore, connected to this is the western model of professionalism on which doctors rely. According to this model, certain characteristics are attributed to genuine professions. The first is autonomy in that professionals have a high degree of control of their own affairs; they are able to make independent judgments about their own work and also possess autonomy of clientele (Kalble, 2005). This power of autonomy flows from the fact that professionals are assumed to have broad theoretical knowledge having undergone an extensive period of formal training and passed the prescribed examinations as well as institutionalized training following this (ibid). Furthermore, professions are regulated by registration and licensing procedures as

well as a code of ethics. Professions are also characterized by a unique body of knowledge which is inaccessible to the uninitiated. Professions also usually have a professional body, organized by its members, to control entrance requirements and performance, or lack thereof, of its members. Finally, professions must also contribute to the public benefit and the earning of fees by professionals is therefore justifiable (ibid). This western construct of professionalism excludes those who do not comply with such standards from being deemed professionals and in this way removes any legitimacy from individuals who may operate within a different paradigm, as is the case with THs.

Ultimately, it is evident that the biomedical model is reductionist in its approach as it adopts a microscopic view of disease and illness and reduces such to specific biological causes. However, while this model originally overlooked any link between the mind and the body (Fremont & Bird, 2000) in the cause and treatment of illness and focused primarily on chemical intervention in the treatment of illness, it is now allowing for the inclusion of social and psychological interventions in addressing disease. These types of interventions, however, are still forced to operate within the scientific paradigm as the biomedical model makes little room for practitioners who operate within a different paradigm.

For this reason THs are not seen as important role players in addressing disease according to the orthodox biomedical model. However, in light of the seriousness of the epidemic as well as its impact and the burden it places on allopathic health care practitioners (Gilbert, 2008) it is of importance to explore whether some form of collaboration is possible. The differences between the allopathic and traditional medical realm as well as the specific obstacles preventing collaboration are therefore addressed in this study.

Although the biomedical model continues to dominate the medical establishment it is increasingly being challenged by advocates of a psychosocial environmental approach to health and illness, particularly with the shift towards primary health care in the South African public health care system. Since THs originate in the community and operate within the psychosocial domain, the current atmosphere may open the way for a more receptive environment to traditional medicine and this is further explored in the study.

The Psycho-Social Environmental (PSE) model

The social model differs significantly from the biomedical model in various ways. It highlights a different understanding of the nature and cause of health and illness, the appropriate intervention methods, the role of the patient during treatment and the consequence of illness. While the biomedical model relies on causes of disease that are purely biological in nature, the social approach identifies numerous causal factors of disease and illness. This approach emphasizes the role that social factors play in causing (or preventing) disease i.e. the behaviour and mindset of individuals, their type of employment, their geographical location and how they live their daily lives (Gilbert, Selikow and Walker, 2002). In this way, the social model offers more of a 'macroscopic' (ibid) view of health and illness and offers solutions that are dependant on the examination of the patient within his/her broader social context. The social model determines the effective treatment of disease according to treatment of different social aspects of the individual. Unlike within the biomedical model, the patient within the social model is regarded as an active participant in the treatment of disease (Armstrong, 2000). Furthermore, while the biomedical approach focuses primarily on treatment and cure of disease the social approach extends its focus to care and disease prevention whereby healthy lifestyle becomes imperative (Tarlov, 1992). The biomedical model is unable to focus on this area, as it relies on the pathological lesion premise which is non-existent in a healthy individual. The starting point of the social model however, exists prior to any lesion and seeks to prevent such from occurring by promoting a healthy lifestyle based on 'healthy' social factors. Finally, while the biomedical model regards impact of illness simply in terms of the individual status of the sick, the social approach considers impact in terms of the wider social identity of the patient (Armstrong, 2000).

While the social model does not deny the links between disease and specific aetiology it seeks to determine the various social conditions that would allow this germ or parasite to flourish and to address these conditions (Gerhardt, 1995). The solution offered by the biomedical model to the HIV/AIDS epidemic, for example, consists of the rollout of ARVs while the social model acknowledges the importance of such but incorporates solutions that address social issues, which allow the disease to thrive, including type of employment, living conditions, sexual and gender relation as well as gender and violence. Furthermore, while the biomedical model considers the

biological impact as the primary consequences of HIV/AIDS on an individual, the social model views the consequences in terms of the individual's social status, that being, for example, his role in society as a father, worker, sportsman etc.

In terms of the PSE model with regard to HIV/AIDS, Traditional Healers can play an important role as they consider the disease in terms of its broader causal and communal factors and take these into account when treating their patients (UNAIDS, 2000). Traditional healers therefore could potentially serve as important components of the PSE model and can offer solutions that may fill the gaps of the existing health care system with regard to HIV/AIDS throughout the disease trajectory from prevention, treatment and care. This study focuses on this area and further explores these issues.

Although the biomedical model and the PSE model represent different approaches to disease and illness they must not be viewed as existing on opposite ends of the spectrum but rather, they must be accepted as different approaches that are able to compliment one another and together provide adequate solutions to disease and illness through a system of Medical and Health care Pluralism. This study therefore investigates what conditions must be met in order for THs, as potentially operating within the PSE model, to function alongside medical doctors in addressing the AIDS epidemic

Medical and Health Care Pluralism

Medical and Health- Care Pluralism refers to the coexistence and availability of different ways of perceiving, explaining and treating illness (Cant, and Sharma, 1999). It is a state whereby different healing systems coexist but are based on completely different world views. The coexistence of allopathic medicine and Complementary and Alternative Medicine (CAM) in contemporary society demonstrates that medical and health-care pluralism is not simply a hypothetical ideal but a reality. CAM refers to “a group of diverse medical and health care systems, practices, and products that are not presently considered to be parts of conventional medicine” (Stratton and McGivern-Snofsky, 2008: 1). CAM has existed for a long time but with the recent shift in focus from a biomedical approach to more of a psychosocial environmental one, CAM has become more relevant and more in demand. The understanding of health and illness not simply in terms of biological

explanations but rather as the effect of broader factors in conjunction with biological accounts has resulted in many individuals placing greater faith in CAM. This is due to the fact that CAM is not simply focused on addressing the specific pathogen but also the broader causal factors of disease and illness.

Furthermore, the use of CAM enables greater personal control in the treatment process and makes this process more meaningful to the patient. Many individuals feel dissatisfied with allopathic treatment as it can be highly disempowering and may produce iatrogenic side effects. The side effects of CAM, on the other hand, are minimal and easier to manage (McQuaide, 2005). The meaning acquired from the use of CAM is often related to individuals' spiritual and religious beliefs as those who believe their illness is a manifestation of something much deeper, or controlled by a higher power are able to find comfort in the use of CAM in that it addresses these factors, and pays attention to the connection between mind, body and soul (Stratton and McGivern-Snofsky, 2008).

CAM however is not only employed by those seeking to avoid allopathic treatment but is often used in conjunction with such treatment. In this way CAM is able to fill many of the gaps of allopathic treatment without interfering with such treatment (ibid). While CAM refers to different approaches that do of course vary with regards to the specific treatments and the focus of such treatments, all place emphasis on removing the cause of the illness and assisting the body to heal itself, as opposed to treating the symptom and 'fixing' the body. In order to achieve such, treatment, remedies that are prescribed are holistic in nature and address the mind body and soul of the individual. The CAM paradigm also differs significantly to the biomedical paradigm in that objective analytic methods to assess efficacy of treatments are not valued. CAM does not rely on randomized control studies and statistical inferences but rather emphasizes the significance of immediate and personal experiences (Kaptchuk & Miller, 2005). Furthermore, CAM recognizes the effects of the health practitioner as a fundamental component of treatment and although there does exist an appreciation of the need for the evaluation of safety and efficacy of individual parts of treatment, the overall effectiveness is determined from an assessment of the entire therapeutic encounter (Anthony, 1987).

In South Africa, the use of the biomedical and non-biomedical systems or CAM, the most common being TM, by the same person has existed for a long time. In previous years the disparagement with which medical doctors view the traditional indigenous system was not as great (Muller and Steyn, 1999). Today however, most medical doctors and THs, like other CAM practitioners, are wary of one another; this in turn makes it difficult for those who wish to incorporate both types of healing systems within their treatment plan. However, examples from other countries demonstrate that despite the different theoretical and practical paradigms of the allopathic and CAM systems it is possible to find a collaborative solution. The Gaynor Integrative Oncology centre in Manhattan is one such example. This centre provides specialized treatments for cancer patients that include allopathic and CAM approaches. The oncologists and CAM practitioners have developed a means of working together within their different paradigms. This example suggests that a successful integrated response to disease and illness depends on the existence of institutions that provides both allopathic and alternative treatment options (Gaynor, 1995).

Another, more local albeit small scale, example of collaboration occurring between allopathic and traditional health practitioners is in the Valley Trust in KZN. The THs there treat patients with traditional methods if they feel it is appropriate or refer them to the doctors in the clinics. After consultation and treatment by the medical doctors the patients then report back to the THs (HST UPDATE, 1998). This partnership has proven successful as these THs and medical doctors are aware of what the other offers and an environment of mutual respect and acknowledgment has been developed.

Both these example are useful in demonstrating that different health systems, informed by different theoretical frameworks, are capable of working together to provide an collaborative response to disease and illness. In light of this, it is necessary to determine whether there exists an opportunity for this type of collaboration in South Africa. The obstacles that are preventing effective collaboration between THs and medical doctors must be carefully assessed and it must be determined where and how such obstacles may be overcome and whether there is room for types of institutions that provide both forms of health care.

Traditional Healers in South Africa

The World Health Organisation defines a TH as:

“Someone who is recognized by the community in which he or she lives as competent

to provide health care by using vegetables, animal and mineral substances, and certain other methods based on social, cultural and religious background as well as the prevailing knowledge, attitudes and beliefs regarding physical, mental and social well-being...” (Cook, 2009: 267)

There are four types of recognized THs.

Inyangas/ Amaxhwele are herbalists and use curative herbs and medicines of animal origin in their treatments. Ninety percent of Inyangas are male (Kale, 1995) Isangomas/ Amaqqirha are diviners and they determine the cause of illness by referring to ancestral spirits. Ninety percent of isangomas are female. One cannot choose to become an isangoma but can only respond to a calling (ibid) Umthandazi/ Abaprofeti are faith healers. They belong to African churches and heal using prayer and holy water (ibid) Traditional birth attendants (Ababelethisi/ Abazalisi) are elderly women and supervise a number of deliveries in the rural areas (ibid). It is estimated that 200 000 traditional healers exist in South Africa and 80% of the population makes use of them (Cook, 2009).

For the purpose of this research report traditional healers will refer only to inyangas/ amaxhwele and isangomas/ amaqqirha as most of the literature suggests that these two categories of Traditional Healers are the ones who deal with issues of HIV/AIDS. Furthermore, practices of both these type of traditional healers often overlap.

The Traditional Health Care system can only be understood by referring to the culture from which it emerged. Indeed, as Muller and Steyn note, culture is essential in understanding health systems as the beliefs and values present in a culture determine the health views of the particular culture which in turn results in the development of specific health systems which take into account these views (1999). While we must recognize the limitation of using the cultural standpoint, in that it can produce a very reductionist analysis, it is necessary to refer to the ‘African culture’ and the way in which disease is viewed within this culture. In general, the African perception of disease includes supernatural causes as well as naturalistic causes (Muller and Steyn, 1999). THs therefore refer to primary and secondary causes in addressing illness. The former refers to factors that cannot be described in physical terms but rather relate to supernatural entities or stresses caused by immorality or unhealthy relationships. The latter category shares similarities with the biomedical model of disease and illness

whereby a pathogen is seen to exist and may be treated symptomatically. THs can be regarded as providing treatment that is more holistic in nature, taking into account the physical and psychosocial aspects of disease (Pretorius), which is congruent with the African culture. THs therefore have credibility, acceptance and respect among the African population (Peltzer and Mngqundaniso, 2008).

This is one of the fundamental reasons that a majority of the population in South Africa consults THs. The treatment is seen as more culturally specific compared to allopathic treatment (Muller and Steyn, 1999) and each treatment is specifically constructed depending on the individual and the primary causes of the illness. Furthermore, because THs are culturally close to their patients this facilitates communication about disease and related social issues and therefore addresses one of the gaps of allopathic treatment (UNAIDS, 2000)

TM is not only culturally more available than allopathic medicine but is also physically more available (Peltzer and Mngqundanison, 2008:). This is due to the fact that for every 100 000 people there are only 77 medical doctors as opposed to 500 THs. These traditional healers are also located within the communities they serve and access to them is therefore convenient (Cook, 2009). The medical health care system does not offer such convenience with the nearest clinic often located far from places of residence.

It is important to clarify one of the misconceptions about TM. While many are of the view that the popularity of Traditional Medicine is due to its economically viable nature this is in fact not always the case. While some THs adopt a ‘no cure, no pay’ policy (Stekelenburg et al, 2005: 74), others charge exorbitant amounts that are not necessarily affordable for all (Muller and Steyn, 1999:).

Ultimately, it is evident that there are a number of reasons for the existence and popularity of TM in South Africa. While it may not always be affordable, it is physically, socially and culturally more available than allopathic treatment. Furthermore, the Traditional health care system is client centered and personalized, paying due regard to social and spiritual matters that are fundamental to African cultures (UNAIDS, 2000).

Traditional Healers and HIV/AIDS

Since the beginning of the HIV/AIDS epidemic, a large number of individuals have consulted both biomedical doctors and THs in order to treat the disease (UNAIDS, 2006). In fact, the population that has been most affected by HIV/AIDS, that being the African population, is the one in which the majority of individuals consult THs. It was therefore evident from the outset that TM needed to be incorporated with allopathic medicine in order to address the epidemic. Attempts to integrate the two systems began in the 1990s when the WHO recommended that traditional medicine be incorporated in national responses to HIV/AIDS (ibid). Following this, some collaborative initiatives between traditional and biomedical practitioners were developed in various countries. Some of these initiatives included incorporation of THs in the formal health care system while others involved smaller collaborative projects. These efforts demonstrate that collaboration is possible and advantageous. However, although collaborative efforts are effective there exist, on the whole, only a small number of such projects (UNAIDS, 2006). Many countries have generally not been successful in developing effective collaboration between the two systems (Geminder, 2008). This is the case for South Africa. Although there are some examples of collaboration occurring these are small-scale and are the exception rather than the norm (Richter, 2003). In contrast, policies that recognize the role traditional healers must play in the formal health care system are available.

The African Union and the South African Development Community have adopted resolutions urging countries to develop national policies and regulations on TM. At the Lusaka Summit of Heads of State the African Union adopted a Plan of Action on the decade for African Traditional Medicine (2001-2010) (Draft National Policy on Traditional Medicine in South Africa, 2008). The purpose of the Plan of Action is the institutionalization of TM in the public health systems of member states by 2010. South Africa has taken further initiatives since. The government established a Directorate of Traditional Medicine in 2006 in order to deal with issues relating to Traditional Medicine within the Department of Health (ibid) and The Traditional Health Practitioners Act was enacted in 2007 (Act no 22 of 2007), which seeks to establish the Traditional Health Practitioners Council. However these initiatives have not resulted in the integration of TM within the formal health care sector and a new Draft National Policy on Traditional Medicine in South Africa (Notice 906 of 2008) has been developed to provide guidelines on the recognition and institutionalization of

TM. Whether this draft policy succeeds in attaining the aforementioned goal remains to be seen, however there continues to exist numerous obstacles in integrating the two health care systems.

These obstacles are often understood in terms of the downfalls of TM. More specifically, that recognition of TM is problematic as training and licensing of THs is not institutionalized, that there does not exist a monitoring system of THs which results in a number of practicing healers that are not bona fide and that THs lack anatomical and physiological knowledge (UNAIDS, 2000). Furthermore, there is concern that THs engage in some harmful practices and may cause delays in referral to biomedical facilities (ibid). There have in fact been recent studies conducted which examined the effects of both African Potato and Sutherlandia (cancer bush) on the metabolism of ARVs. These studies found that both herbs inhibited the metabolism of ARVs considerably (The Sunday Independent, January 30, 2005). While this demonstrates that concerns with regard to TM are not unfounded some of them, as noted in the introduction, are based on information that is outdated. While in the past many THs held beliefs, specifically about HIV/AIDS, that were erroneous this is not as much the case today (Wrefford and Esser, 2008). It is therefore essential to assess the beliefs and practices of THs nowadays and explore how they integrate biomedical concepts into their traditional belief system and methods of practice in dealing with HIV/AIDS (UNAIDS, 2000).

A study conducted by Dickinson (2008) assessed the viability of collaboration between TM and allopathic treatment in workplace responses to HIV/AIDS. While it was found that differences of opinion existed with regard to understandings of HIV/AIDS among THs, Dickinson shows that there is a fair degree of internal logic and that much can be regarded in parallel to western understandings of HIV/AIDS. Dickinson also shows that there are many disadvantages with the traditional health care sector. These include the absence of a shared storage area of knowledge but rather the existence of a fragmented and secretive approach to knowledge, which prevents the flow of information within the profession, as well as the competition between healers as entry into traditional healing cannot be limited. Many studies, however, that assess the possibility of collaboration simply explore the position on behalf of THs and do not take into account the views of allopathic practitioners. These studies, therefore, while critical of the one sided nature of collaborative efforts do not

address this problem by simply focusing on the neglected side. It is therefore necessary to explore the position on behalf of THs as well as allopathic practitioners in order to establish whether the development of a cooperative environment between the two is possible.

Furthermore, while policy has emerged in order to recognize and institutionalize TM very little action has been taken on behalf of the medical establishment to actually work with healers and the reasons for this need to be further explored. In addition, these policies have been constructed and are written in the language and terminology of the biomedical paradigm but as of yet there exists no such policy written by and for THs using their own language, terminology and belief system (UNAIDS, 2006). Often, these policies are about restructuring TM in ways that suit the biomedical paradigm and are contradictory to the beliefs embedded in the traditional healing system (MediaGlobal, 2008). Furthermore, although many medical professionals agree that collaboration with traditional practitioners is necessary, they advocate this only under a hierarchical system whereby biomedicine holds priority (Mall, 2005). It is therefore evident that the differential powers between the different paradigms may constitute an important barrier to collaboration between these paradigms. This study further investigates this potential barrier seeking to demonstrate whether and how it can be overcome.

Theoretical Framework

This research project is located within a broader theoretical framework of Medical and Health care Pluralism as well as the different paradigms of the biomedical and the psychosocial environmental models of health and illness. The shift from a purely biomedical approach to disease to more of a PSE approach whereby broader factors are taken into account serves as an important component of the study. It is examined how THs practice in line with the PSE model and how they provide treatments that are holistic in nature, taking into account the broader social and environmental factors of the individual. This is relevant with regard to HIV/AIDS as prevention and treatment strategies are no longer focused on simply biological factors but are seeking to address the broader social factors that contribute to the spread of the epidemic. This serves as an area where THs can serve as an essential component in the struggle against the epidemic.

The literature on medical and health care pluralism informs the study in the area of potential collaboration between the two health care systems in South Africa. While it has been acknowledged that collaboration is necessary, examples of such occurring in South Africa are minimal and anecdotal. The literature does consider potential obstacles that are preventing collaboration however a comprehensive and nuanced assessment of such is lacking. Furthermore, many of the views are based on studies that are outdated and it is therefore necessary to establish what the obstacles are today and whether these are based on different and competing views between the two systems that cannot be reconciled or whether THs are not being given enough credit concerning their beliefs and practices and that such obstacles may be due to the unwillingness on behalf of the biomedical establishment to truly accept and incorporate TM into the health care system.

Ultimately, in light of the HIV/AIDS epidemic, and the fact that the population most affected by the epidemic is the one in which a majority of the individuals make use of THs, collaboration between the two systems could be beneficial. Further, due to the heavy brunt of the epidemic borne by society as a whole and health care personnel, in particular, this may be the necessary trigger for the incorporation of TM into the formal health care system. However, the forces that hinder this process must be fully understood in order to comprehend the conditions that will allow for any collaboration to occur.

METHODOLOGY

Qualitative research methods were used in order to address the research question: Qualitative research refers to a non-mathematical analytic procedure (Strauss and Cobrin, 1990:18). There exist three components of qualitative research. The first being the data, which can come from many sources, the second being the different analytic or interpretive procedures known as ‘coding’ and the third being the written and verbal reports (ibid: 20). Strengths of qualitative research lie in the ability to uncover and understand phenomena in greater detail as the underlying issues of phenomena are uncovered (ibid: 19). Qualitative research was appropriate for this specific research question as I was concerned with uncovering detail and underlying issues surrounding the obstacles preventing collaboration between the traditional and allopathic health care systems. The types of qualitative methods employed were in-

depth interviews, a focus group as well as content analysis. Interviewing is frequently used in the social sciences. It is an important method as “Interviewing can inform us about the nature of social life” (Weiss, 1995:1). Interviews allow us to explore a wide range of circumstances, beliefs, attitudes and actions of organizations, social groups and individuals. Furthermore, as Greenstein notes, “The goal of getting detailed and unstructured responses can be achieved more efficiently by using the in-depth interview method” (2003: 23). This method was therefore appropriate to address my research question, as it enabled the development of a detailed understanding of the views on behalf of traditional healers as well as allopathic practitioners.

In-depth qualitative **interviews** were conducted with two THs and a key informant within the traditional health care sector as well as with 5 medical doctors.

In addition, two **focus groups** were conducted, one with six medical doctors and another one with four THs. Powell et al define a focus group as “a group of individuals selected and assembled by researchers to discuss and comment on, from personal experience, the topic that is the subject of the research”. (1996: 499). The advantages of using focus groups are that participants often feel less intimidated than in one-on-one interviewing and will therefore be more open. Furthermore, focus groups enable the participants to interact and question one another whereby a range of views are expressed. In my case, this method was not originally chosen but was used because both the group of doctors as well as the THs requested that it occur this way. Furthermore, it was advantageous for me as these doctors and healers were located in distant areas and making more than one trip would have been very time consuming.

Purposive sampling as well as **snowball sampling** was used in order to select both the Traditional Healers as well as members from the medical establishment. Purposive sampling is appropriate when a researcher wants to target particular individuals or categories of individuals for investigation (Greenstein, 2003: 27). This was relevant in my case as I was only interested in THs who deal with HIV/AIDS treatment and prevention as well as members from the medical establishment who are involved in HIV/AIDS work. Snowball sampling was also used in order to target individuals who were difficult to reach (Greenstein, 2003: 27).

Content analysis, as a research method, was originally used to study mass

communication in the 1950s. Today however, content analysis is used in many different areas of study and applies to almost any form of communication and includes document analysis. Although Mariampolski and Hughes deal with historical document analysis some of the requirements they highlight apply to any kind of document analysis. Firstly, one must ensure that the documents are representative of the larger phenomenon that is being studied. Secondly, the data must be adequate in that it must reflect the full range of responses and lastly, the documents must be reliable (Mariampolski and Hughes, 1978:108; Bryman, 2001)

The documents analysed were selected from official government policies. These types of documents were appropriate from my analysis as I was seeking to investigate the position on behalf of government towards recognition of THs. These documents can be viewed as representative of government's position as they are published in the government gazette and therefore also constitute reliable sources of information. The specific policies that were chosen were ones either specifically dealing with TM and its practitioners or health policies in general, with special focus on HIV/AIDS policies. The former enabled a more explicit understanding of the position on behalf of government towards THs while the latter required more of an inferential procedure of analysis. Due to the fact that my study was focused specifically on HIV/AIDS the health policies that were chosen were appropriate as it was necessary to establish whether, and how, THs are mentioned in such.

This method of document analysis allowed me to analyze government policy on traditional medicine and to make inferences about the way in which government views traditional medicine and potential collaboration between the two health care systems.

According to de Vaus, the type of research methods employed must ensure that the necessary evidence is collected in order to address the research question (de Vaus, 2001:9). In this case the in-depth interviews as well as the focus groups and the documentary analysis enabled me to collect the kind of evidence required in order to address my research question.

Limitations of the Research Methods

The main limitation of any type of qualitative research is that it is usually rich in

description rather than representative. Furthermore, both THs and medical doctors are not a homogenous group and therefore it is not possible to make generalizations beyond the participants and beyond the documents that were chosen. However, the information generated by this study will hopefully inform further research into the area and may ultimately result in findings from which sound generalizations may be made.

Another limitation, in my case, was that access to the THs was very difficult firstly because they were not easy to locate and secondly because they were wary of speaking to someone who was not part of their culture. In addition the language barrier between the healers and me proved to be another limitation. In the end I was able to locate some THs, mainly because of a contact I had, but not as many as I originally hoped for and I made use of a translator in the interviews with those who preferred to speak their own language.

In this way I was able to collect enough data in order to generate my findings.

Ethical Considerations

This research study operated on the principle of informed, voluntary consent. The participants were provided with a participant information sheet, describing what the study is about and what is expected of them, as well as a consent form. It was made clear that participation was entirely voluntary and that participants had the right to leave the study if they so wish. The confidentiality of the participants has been protected by the use of pseudonyms throughout the research report. An application to the Wits Ethics Committee (Non-medical) was submitted and approved.

POLICY ANALYSIS

In order to better understand the current scenario with regard to collaboration of THs & medical doctors, there is a need to critically examine the available official documentation on this topic in a historical context.

Under the apartheid government Traditional knowledge of African communities was marginalized. In 1953 the Medical Association of South Africa proclaimed all alternative therapies illegal and unscientific and cooperation between allopathic and

alternative practitioners was prohibited (ALP, 2007). In 1957, the Witchcraft Suppression Act was passed and was amended in 1970. Both the Witchcraft Suppression Act as well as the Witchcraft Suppression Amendment Act prohibited the practice of diviners (ibid). In 1978 the positive role of THs was given international recognition by the WHO at the Alma Ata Declaration on Primary Health Care (Muller and Steyn, 1999: 142; Mills: 2005: 127). This commitment was renewed in 2002 when it was more effective in influencing the development of official policies on TM than in 1978. Although small initiatives emerged on behalf of the biomedical establishment to incorporate THs into health care programmes (Gqaleni et al, 2007) formal policies dealing with such only emerged from 1994

The ANC National Health Plan for South Africa, 1994

As early as 1994 the ANC National Health Plan recognized the importance of Traditional Healers and submitted that Traditional Healing would become an integral and recognised part of health care in South Africa (ANC, 1994: 44). The Health Plan stated that consumers would be allowed to choose whom to consult for their health care, and legislation would be changed in order to control the use of traditional practices (ibid). The support of traditional healing was based on two aspects. The first was related to the limited health resources available to individuals and the potential of THs, among others, to fill this void. The second aspect was supposedly related to an extension of democracy in the context of post-1994 South Africa in that individuals should be empowered to take care of their own needs instead of the state doing it for them (Mills, 2005). The Health Plan recognized the benefits of Traditional Healers in that they often have greater accessibility and acceptability within communities than allopathic practitioners and is therefore consistent with the views expressed by Peltzer and Mngqundanison (2008). The limitations of traditional medicine were also recognized, as pointed out in the UNAIDS 2000 Report, and the need for Traditional Healers to be controlled by a regulatory body in order to eliminate harmful practices, as well as the need for training programmes was outlined (ANC, 1994).

On the issue of collaboration, the Health Plan seems to have been explicit as it states that cooperation and liaison between allopathic and traditional health practitioners is advantageous and interaction will therefore be promoted, specifically at local levels (ANC, 1994: 44). The Plan, however, does not specify how this ought to occur. It states that in order for the policy principles to be translated into action negotiations

will take place with THs in order for appropriate policy to be developed and that legislation altering the status of THs will be enacted. These vague commitments are inadequate in ensuring that implementation will follow as they do not stipulate how and when such interaction will be promoted nor do they specify who will be responsible for driving negotiations with THs. The absence of a specific time frame in order for goals to be achieved suggests that the recommendations within the Health Plan are simply theoretical and that a commitment to achieving these ideals is lacking. Furthermore, the Health Plan states that training programmes will be initiated and calls for mutual education between the two health systems so that the practices of all health practitioners can be enhanced (ibid). This seems to address many of the concerns expressed by some of the authors of the one sided nature of training programmes (Mall, 2005; MediaGlobal, 2008) however, once gain, the Health Plan is not explicit enough in outlining how this will occur.

It is evident that the 1994 Health Plan is supportive in principle of collaborative efforts between THs and allopathic practitioners. The type of collaboration envisaged is one in which each health system would enhance the other through mutual respect and learning but practical implications and considerations are lacking.

The Plan does recognize that TM ought to be regulated and controlled and it is implicit in this that regulation is a precondition for collaboration to occur. However, the Health Plan did not sufficiently develop a plan of action in order for the abovementioned goals to be met.

While the Plan must be commended for recognising the importance of including THs in the deliberation process in order to develop an appropriate policy, it did not pay enough attention to the way in which the objectives would be accomplished and ultimately did not achieve its objectives. If the Plan had been more precise in terms of its recommendations and had resulted in the implementation of such the current situation would be very different. While speculations are difficult to make, it can be assumed that many of the obstacles preventing collaboration between medical doctors and THs would already have been addressed and many may have been overcome. In reality, because concrete steps were not taken to facilitate interaction between healers and doctors, the disparagement between the two sectors heightened

Pretorius shows that since 1994 some medical schemes had enabled employees to claim a certain number of visits to a TH on the company's medical scheme. This however changed when the Medical Schemes Act was passed in 1998 as medical scheme claimed they were only required to reimburse registered providers (Gqaleni et al, 2007)

The National Drug Policy for South Africa, 1996

This Policy of 1996 expresses similar sentiments to the National Health Plan. Although Traditional Medicine is not dealt with in detail, one of the aims in the Policy is to investigate the use of effective and safe TM at primary level. In order to achieve this, the Policy stipulates that Traditional Healers will be encouraged to work more closely with the formal health care sector, particularly with AIDS management, but without becoming part of the sector (Department of Health, 1996: 26) Furthermore, the Policy states that the investigation of TM is necessary in order for it to be incorporated within the health care system and that TM would be registered and controlled (ibid). Another objective of the Policy is the establishment of a national reference centre for TM that would develop a national database of indigenous plants that have been screened, test for toxicity and efficacy, compile lists of traditional medicines approved by the Medicines Control Council and control propagation of medicinal plants (ibid). The policy evidently places importance on regulating TM in order to ensure the safety and efficacy of practices. It is evident that the Policy recognizes collaboration to a certain degree as it stipulates that THs must be encouraged to work more closely with the formal health cares sector and that TM must be incorporated into the health care system (ibid). However, it is clear in the policy that THs should not necessarily become a part of the formal health care system. "The aim will be achieved through the encouragement of traditional healers to work more closely with the formal health care sector, although this will not necessarily be aimed at making them part thereof" (DOH, 1996: 26).

One can infer from this that TM should operate as its own system but that collaborative efforts should be fostered. However, the policy only mentions the encouragement of THs to cooperate and work more closely with members of the formal health care sector and, although this does imply that the latter will be encouraged to work more closely with the former, this is not explicitly expressed and therefore may infer that collaborative efforts will be one sided and dominated by the

biomedical model, as shown in the literature (Mall, 2005). Furthermore, like the National Health Plan of 1994, this Policy also does not specify how such cooperation ought to be achieved and who will be responsible for driving these cooperative efforts. This is a significant shortfall as one cannot expect implementation to occur without the necessary direction. The National Drug Policy ultimately did not result in the development of collaborative efforts and, like the Health Plan, remained theoretical

The Operational Plan for Comprehensive HIV/AIDS Care, Management and Treatment for South Africa, 2003

This Operational Plan was developed in 2003 and seems to address some of the gaps of the two policies mentioned above. The Operational Plan dedicates an entire chapter to TM. It provides a background analysis of TM and emphasizes the positive and influential roles that THs play in African communities and stresses the importance of incorporating TM into the national health system (Department of Health, 2003:86), and is therefore supportive of the Plan of Action developed by the African Union at the Lusaka summit calling on member states to institutionalize TM into their public health systems (Draft National Policy on Traditional Medicine in South Africa, 2008: 5). THs are regarded in the Operational Plan as an essential component of the continuum of care with regard to HIV/AIDS. The Plan explicitly uses the word collaboration and stipulates that several stages are necessary in order to ensure that such occurs between THs and biomedical workers (DOH, 2003).

The first stage is to strengthen dialogue between national and provincial Traditional Health Practitioner Organisations and conventional Medical Practitioners. The aim of this is to further involve THs in health care programmes. With regard to the comprehensive care and treatment programme, outlined by the Plan of Action, the role of THS is seen as potentially effective in the implementation phase of the programme and further collaboration is seen as possible in the long term. Furthermore, the Plan states that more specific efforts will incorporate THs as collaborators in the clinical management of HIV- infected patients (DOH, 2003: 88-89)

The second stage refers to the involvement of THs in the programme for the care, management and treatment of HIV/AIDS. In terms of this, training will be given to

THs to expand their knowledge on HIV. This would include training on HIV prevalence and care, adherence to medicine, general counseling, toxicity monitoring and patient education. The role of THs in the implementation process of the programme is therefore viewed as fundamental. Furthermore, the Plan requires that a report be developed by a team of representatives including, among others, those from the Department of Health, biomedical practitioners and THs. The report is to describe the role of THs in South Africa, the current status of collaboration with biomedical practitioners in prevention, care and treatment practices, and the aspects of TM that may enhance HIV care. The report is also meant to assess the level of interest of THs in this collaborative effort and provide a basis for developing further collaborative efforts (DOH, 2003).

The third stage is the development of enhanced referral systems. According to this, an open channel of communication should exist between the different health practitioners used by the patient. The aim is for THs and biomedical workers to connect their referral networks and in turn make better use of these networks. It is evident that the Plan seeks to address the issue of the one sided nature of collaborative efforts, as discussed in the literature, and aims to ensure that a system of cross referral and reciprocal communication will occur (Mall, 2005; MediaGlobal, 2008). The Plan also stipulates that Protocols will be developed in order to evaluate the most appropriate way to engage with THs in order to guide the implementation of the care and treatment programme within communities (DOH, 2003: 90)

The fourth stage is the development of quality assurance mechanisms with regards to TM in relation to HIV/AIDS care and treatment. This Plan also envisages that TM be incorporated into the pharmacovigilance process (DOH, 2003: 91).

The last stage refers to training activities and priorities. The aim of this is that information about traditional practices be incorporated in training programmes offered by Health Promotion and Quality Assurance Training Centres. The outcome of this should be a mutual learning platform whereby biomedical practitioners are informed about the role and methods of traditional practice while THs are provided with information on ARVs and HIV care (ibid). Once again it is clear that the Plan recognizes the importance of mutual engagement between the two paradigms and if practical steps were to follow the problems discussed in the literature of unequal

power relations between the two paradigms may be addressed (Mall, 2005; MediaGlobal, 2008)

It is evident that the Operational Plan recognizes the need for regulation of Traditional Medical system as it stipulates that it be incorporated within the pharmacovigilance process and supports the establishment of a traditional health practitioners' council in order to regulate the process (ibid). In terms of collaboration between THs and medical practitioners, the Plan is explicit and envisages this occurring through a process of communication and mutual learning whereby medical practitioners are taught about traditional practices while THs are trained in areas of health care and HIV prevention and treatment (ibid). The Plan emphasizes the need for dialogue between the two paradigms in order for collaboration to occur and sees the importance of the operation of two-way referral systems. It is obvious that the Plan considers the role of THs as fundamental with regard to HIV/AIDS and seeks to incorporate them as partners in prevention and treatment, and is therefore supportive of the recommendation made earlier by the WHO of incorporating THs in national responses to HIV/AIDS (UNAIDS, 2006) Furthermore, the type of training and referral stipulated by the Plan is not simply one sided but also focuses on the advantages that THs can offer to the biomedical establishment, through a system of mutual leaning and communication.

While the Operational Plan is, for the first time, nearly 10 years after the ANC health plan, comprehensive in its recommendations, the translation of these into practice has evidently not occurred to date. The Plan stipulates that the Department of Health and the Traditional Health Practitioners Interim Council, and its permanent successor, will be responsible for ensuring that collaboration is ongoing and for the implementation of the recommended programmes and projects. As of yet a council of Traditional Healers has not been established and a partnership between traditional healers and the department of health has not developed. No more than lip service has therefore been paid to the Operational Plan and training programmes that have been developed since are one sided and seek simply to educate THs on issues of HIV/AIDS and to encourage a one sided referral system form THS to medical practitioners and not vice versa.

The HIV & AIDS and STI National Strategic Plan for South Africa 2007-2011 (NSP)

The NSP 2007-2011 was developed as an assessment of the NSP 2000-2005. The primary goals of the NSP are to reduce the rate of new HIV infection by 50% by 2011 as well as to reduce the impact of HIV/AIDS by expanding access to appropriate treatment, care and support to 80% of all HIV positive people and their families by 2011 (Department of Health, 2007: 10). In order to achieve these goals key priority areas are outlined. These include prevention, treatment care and support, research, monitoring and surveillance, human rights and access to justice. Throughout the NSP emphasis is made regarding the need for a multisectoral response to the epidemic. This refers simply to different government sectors but also to the private sector and civil society sectors. It is therefore evident that the NSP pays attention to the fact that HIV/AIDS demands an intervention strategy that incorporates different role players as broader factors have come to be understood in driving the epidemic, as shown in the literature (UNAIDS, 2000). The role of THs however, is not specifically considered. Within the 127-page document brief mention is made to THs; this is in terms of support for research on the efficacy of TM and nutritional interventions for HIV treatment (DOH, 2007). Other than that, the NSP mentions that civil society sectors include THs. While it may be inferred from this that the NSP does recognize a role for THs in the multisectoral response to HIV/AIDS it is inadequate to simply place them within the ambit of civil society. Furthermore, the type of role THs ought to play in addressing the epidemic is not outlined. The NSP does state that HIV/AIDS programmes are to be informed and owned by communities and their leaders (DOH, 2007:60) and therefore it is evident that the NSP recognizes the need for a decentralized, community-based response to the epidemic however it does not elaborate upon the role THS may play in this regard. In addition, the NSP makes recommendations for new community care-givers to be recruited and trained but fails to consider the fact that THS, who already exist in large numbers and are influential within the communities (Cook, 2009; Peltzer and Mngqundanison, 2008) may be able to fulfill this type of role with more training

Lastly, the NSP identifies the need to strengthen existing care systems but makes no direct mention of THs and, although dedicated to a multi-sectoral approach, it does not discuss the ways in which the Department of Health will establish partnerships with other sectors in order develop an integrated response (AFESIS, 2007). The NSP should have included clear strategies in order to develop effective partnerships and

should have paid more consideration to THs in this regard. Because the NSP, as representative of the national position towards addressing the epidemic, does not pay much attention to the role of THs it cannot really be expected that other role players will include THs in their response to HIV/AIDS. An opportunity existed within the NSP to specify the role of THs within the so-called multisectoral approach however this was not taken advantage of and in turn did not create an incentive for any type of collaborative environment to exist. While the Health Plan of 1994 stated that Traditional healing would become an integrated part of SA health care, the fact that THs are not adequately considered in guiding policy on HIV/AIDS undermines this objective.

The Traditional Health Practitioners Act, No 22 Of 2007

In 2003 the Traditional Health draft Bill was developed and was passed as the Traditional Health Practitioners Act in 2004 (Gqaleni et al, 2007). The Constitutional Court found that the Act was not processed correctly by the National Council of Provinces and ruled that it return to Parliament. After public meeting in the provinces the Act was finally passed in 2007 (ibid). The Traditional Health Practitioners Act is the first legislation, 13 years after the ANC Health Plan, dealing specifically with TM. The fact that it took so long to develop an official policy dealing with TM and its practitioners suggest that this was not an area of priority for the South African Government. Therefore, while the National Health Plan of 1994 made mention of the potential role of THs it can be concluded that this role was not considered seriously and efforts to formalize it were evidently absent. This contributes to an understanding of the obstacle that exist in terms of collaboration between allopathic and traditional health practitioners. If the state is not active in addressing the obstacles and fostering collaborative efforts it cannot be expected that medical doctors and traditional healers would initiate such on their own accord. These efforts need to be driven, or at least clearly supported, by above in order for effective changes to occur on the ground.

The Act aims to

- a) Establish the Interim Traditional Health Practitioners Council of South Africa;
- b) Provide for the registration, training and practices of THs in South Africa; and
- c) Serve and protect the interests of those who make use of the services of THs by setting up a regulatory framework to ensure efficacy, safety and quality of TM (DOH, 2007).

In terms of the Interim Council, the Act stipulates that it must be made up of 22 members including, among others, registered THs from each province, a representative from the Department of Health, a person with knowledge of law and a medical practitioner who is a member of the Health Professions council of South Africa. The functions of the Council are outlined in the Act. These include registering THs, determining codes of professional conduct and ethics, disciplinary procedures and the scope of practices of THs, developing guidelines on TM and its practitioners and controlling and regulating traditional health practice (DOH, 2007: Chpt 2).

It is clear that the Act recognizes the need for registration and regulation of TM and its practitioners in order for recognition to occur. However, while the Act does outline the procedures for registration of THs it does not specify minimum training or practice requirements to become a TH, as this is left to be determined by the Minister of Health after consultation with the Council. On the one hand this is problematic as it leaves the issue of traditional healing qualifications too open and vague. On the other hand, this may be beneficial in that the Act acknowledges the importance of consultation with THs in developing regulatory standards.

A further limitation of the Act is that it only deals with offences in terms of unregistered THs who continue to practice as such. The Act does include provisions for the inquiry into unprofessional activity on behalf of registered THs, but this seems to be more in terms of activities outside of traditional health practices. The Act does not provide regulations for registered THs who engage in non bona fide practices. The act only considers it an offence for non registered individuals to practice as THs and to “prescribe a cure for cancer, HIV and AIDS or any other prescribed terminal illness” (DOH, 2007: 49 g (i)) but does not consider the same type of behaviour that may exist on behalf of registered THs. Without as stringent regulations for registered THs recognition may be problematic.

The fulfillment of this Act ultimately depends on the establishment of the Traditional Health Practitioners Council, which will undoubtedly take a considerable amount of time and raises a number of issues. Dickinson deals with the problem of establishing the Council in terms of need for structures that can nominate appropriate representative from each province to serve on the Council. The reason this is

problematic, according to Dickinson, is that the Act does not consider the current practice of traditional healing but rather stipulates that the Council be established which would then regulate the traditional healing system. This, in turn, has resulted in preparatory organizations of THs not being based on shared rules and practices but rather simply focusing on placing a representative within the Council who will ultimately assist in developing the correct rules and regulations (Dickinson, 2008). Currently there are a number of associations and different organizations to which THs either belong or are in no way affiliated to, and therefore, as Dickinson shows, establishing a Council, with the appropriate representatives, will no doubt prove difficult (ibid).

There are also many other areas of concern with regard to the recognition of TM. Some have argued that the scientific methods used to evaluate biomedicine are not appropriate for TM as it is governed by a different belief system and understanding about health and disease (Kaptchuk & Miller, 2005). But without scrutinized testing the recognition of TM on behalf of biomedical practitioners will not be accepted. Some THs have also resisted regulation due to the fact that the process may be costly. Finally, there are also those THs who want to protect their products, as many would be removed from the shelves if scrutinized testing were applied. However, there are also many THs who welcome regulation efforts as they see as much of a need for harmful practices and practitioners to be removed.

The Draft National Policy on African Traditional Medicine in South Africa, Notice 906 of 2008

This draft policy was published in 2008 by the Department of Health in order to provide a basis for the formal recognition and institutionalization of African Traditional Medicine. Considering that the need for the incorporation of TM into the formal health care system was recognized already in 1994 this Draft Policy, like the Traditional Health Practitioners Act, is long overdue. This demonstrates, again, that while in theory government has been dedicated to the recognition of TM little has been done to develop appropriate policies on the matter and, in turn, to translate such into practice. This supports the inferences made earlier that TM has undoubtedly not been a top priority for the South African government and this has, to some extent, contributed to the lack of acknowledgement of the possible benefits of traditional healing within the biomedical establishment. While it is difficult, once again, to

ascertain what would have transpired had official policy like this been developed years before, it can be assumed that the status of TM and its practitioners would be better recognized and respected currently. This, in turn, may have enabled a better relationship to exist between allopathic and traditional health practitioners and collaboration would therefore be easier to achieve.

The Draft Policy has been made available to the public in the Government Gazette and calls for public comments on the policy to be made to the Director General of health.

The type of information within this document includes information regarding TM and its practitioners, current interventions by the government, motivation for this policy, outline of existing legal framework on TM and assessment and recommendations on education, training, research and development with regard to THs. This information is based on assessment of previous documents, including policies, papers, published government reviews and case studies.

The document outlines the concept and philosophy of TM and considers the benefits of recognition and institutionalization of TM. Reference is made to the holistic nature of the TM (Department of Health, 2008: 5), and the fact that a majority of the population continues to rely on this system of healing (DOH, 2008). In this way the Draft Policy is consistent with much of the literature on traditional healing (Cook, 2009; Peltzer and Mngqundanison, 2008; Muller and Steyn, 1999) Furthermore, official recognition, empowerment and institutionalization of TM, as well as its incorporation within the national health system is viewed as an important step towards establishing effective and accessible client based health care (DOH, 2008: 6). The Draft Policy is essentially based on the Plan of Action on the Decade for African Traditional Medicine (2001-2010), which was developed as the Lusaka Summit of State and Government in 2006 (DOH, 2008). The primary objective of the Plan of Action is the recognition, acceptance, development and institutionalization of TM into the public health care system by all Member States by 2010 (ibid). The Draft Policy explicitly states that its intention is directed toward the institutionalization of TM and not its integration with allopathic medicine (DOH, 2008: 7). The goal is for specific structures and a system to be put in place for its institutionalization and for TM to

operate as a separate system within the health care sector but equal in status to allopathic medicine (DOH, 2008:11).

The Draft Policy, like the THPA, also recognises the importance of the establishment of a Council of THs as well as the development of a pharmacopoeia to register and control TM. The need to regulate TM is based on protecting THs and users of TM against unqualified or incompetent individuals acting as THs. Furthermore, the Policy makes a number of recommendations. Some of these include the regulation of TM and its inclusion in the National Health system as well as and Institute of African Traditional Medicine. This Institute will have a number of functions including overseeing the establishment of a school or faculty where education and training in TM and primary health care will be offered to THs, as well as medical students and doctors who wish to incorporate TM into their practice. This faculty will also provide bridging courses between THs and allopathic practitioners (DOH, 2008: 33). In addition, the Policy calls for the inclusion of TM in the curriculum of medical students taught by THs (DOH, 2008: 34) as well as the creation of a hospital or facility where THs can provide health care, either alone or in collaboration with medical doctors (ibid). The Institute will also be responsible for educating the public on TM as well as running education programmes for THs (DOH, 2008:38). In order to achieve the aforementioned goals, the Policy stipulates the development of a national implementation plan by the Department of Health.

It is, once again, evident that the traditional medical system is viewed in a positive light under the Draft Policy. The benefits of TM are acknowledged as well as the need for the system to be regulated in order to ensure efficacy and safety of treatments, and to eradicate non bona fide THs. The Policy does also recognize the need for further education and training of THs but emphasizes the necessity of the creation of an environment in which mutual learning will occur and linkages will be made between TM and other paradigms of health care.

Note should be taken that the Policy does not seek to integrate TM into the health care system but evidently acknowledges the benefits that would flow from collaborative efforts between the different health care systems. While the Policy may be commended for its recommendations, the question of implementation undoubtedly emerges. Indeed, the policy calls on the Department of Health to develop an

Implementation Plan but does not set out the procedures for such and this is where the difficulties have been so far. It will be problematic if the Department of Health develops this Implementation Plan on its own, without a consultative process occurring with THs. THs ought to be directly involved in developing the Implementation Plan in order to avoid biomedical standards dominating and to ensure that an appropriate Plan is developed. Ultimately, only with the creation of an Implementation Plan, and the realization of it, can the objectives within the Draft Policy be fully assessed because as it stands the recommendations remain ideals. This has of course been the problem in general with the many policies that have emerged, as implementation has not followed. While this Draft Policy makes a step in the right direction, as it recognizes the need for an Implementation Plan, the problem still remains of actually developing this and ensuring that it is translated into action. There is also no reference of a time frame for realizing the goals set out in the Draft Policy and hence no incentive for immediate action to be taken in developing the Implementation Plan.

From the Documents analysed it is evident that Government now recognizes the need for the regulation and registration of TM as well as further education of THs. If this could be achieved, collaboration would become easier as many of the suspicions held by medical doctors would be dispelled. As discussed in the UNAIDS report, many allopathic practitioners consider TM to be problematic because THs lack physiological knowledge and because training and licensing is not institutionalized resulting in a number of practicing THs who are not bona fide (UNAIDS 2001). If regulatory mechanisms were developed for the traditional health care system many of these concerns would be dispelled and collaboration may be facilitated.

Many of the documents also recognize the potential benefits in collaboration occurring between THs and allopathic practitioners, and the final document explicitly states the need for mutual learning to occur between the two paradigms. However, there may be problems with the way in which these policies have been developed in that they are constructed and written in the terminology of the biomedical paradigm and although areas of collaboration are considered, the policies are ultimately about restructuring TM in ways the biomedical establishment deems appropriate.

While some type of regulation is undoubtedly necessary perhaps a specific system needs to be developed by THs themselves. This, however, would undoubtedly be problematic for medical doctors as they would remain skeptical about a regulatory system that does not comply with scientific standards and this may ultimately undermine any form of collaboration. The answer however may lie in a collaborative approach to bring about collaboration. This would occur through a consultative process between both allopathic practitioners, including members of the Department of Health, and THs in order to reach an agreement on the types of structures that ought to exist in order for appropriate regulation and collaboration to occur. The reason this has not occurred to date, despite the presence of official policy that advocates a similar approach, is twofold. Firstly, mandatory standards have not been set by government, which perhaps undermines the intentions that may exist and does not provide enough incentive for collaborative efforts to occur. Secondly, a willingness to collaborate on behalf of THs and medical doctors may be lacking and therefore the perception held by both types of practitioners towards the other must be explored. This however, would only be possible if mutual respect existed between the two paradigms, and a consideration of the views of both THs and medical practitioners, with regard to one another, is therefore necessary.

It is clear that since 1994 the South African government has recognized the role that THs should play in health initiatives, specifically those focused on HIV/AIDS. The benefits of traditional healing have been noted and official policy has emerged in order to incorporate traditional healing within the formal health care sector, but as operating as a separate system to it. However, it is clear that a number of issues exist with regard to policies dealing with TM. The main concern is that while in theory support has been given to TM and its practitioners it is questionable whether government has been serious about this support. Firstly, the development of policies dealing specifically with TM only occurred years after the initial recognition of the potential role on behalf of THs in 1994. This demonstrates that issues of traditional healing were not a priority for the government and that support for TM remained theoretical. Secondly, the policies dealing with TM that were established since 1994 are vague in their recommendations and as of yet an effective Implementation Plan of the policies has not been developed. All the documents considered do not adequately specify how and when the objectives are to be met, and who ought to be responsible for driving these objectives. Furthermore, while many of the documents call for the

development of collaborative efforts between allopathic and traditional health practitioners, mandatory standards have not been set and this may be a significant reason as to why collaboration has not yet occurred on the ground.

Finally, although the benefits of traditional healing are noted specifically with regard to addressing HIV/AIDS the NSP does not make specific mention of THs. This is significant as it is unrealistic to expect that THs will be incorporated into HIV/AIDS response initiatives when the guiding National strategy on HIV/AIDS does not distinctively mention them. The objective of the Plan of Action on the decade for African Traditional Medicine that was adopted by the Africa Union at the Lusaka Summit of Heads of State was to institutionalize TM in the public health systems of member states by 2010. Over these past ten years South Africa has not made much practical progress in this regard and as we now enter 2010 it is clear that no more than lip service has been paid to the institutionalization of TM on behalf of the government. This has ultimately undermined collaborative efforts between allopathic and traditional health practitioners and there is a need, therefore, for appropriate policies on TM to be developed through a consultative process with THs, and for the implementation of such to follow if collaboration is to occur.

THE MEDICAL PERSPECTIVE – VIEWS OF DOCTORS

The analysis of the material collected from the interviews conducted with the medical doctors, yielded varying themes with regard to the perception of traditional medicine and its practitioners. The general role that traditional healers play was perceived to be both positive and negative– a finding that adds to the complexity of this issue. Following from this, collaboration was seen as potentially beneficial but also highly problematic by the doctors.

Charlatans, Sadists and Quacks

While some participants held a more extreme view of the perceived negative role on behalf of THs all participants made reference to the harm caused by THs. This was based on past experiences on behalf of the doctors with patients who had consulted THs and, in many of the cases, had died. As one doctor said

I saw a lot of problems with (THs), I saw young men coming and dying from poisoning from a traditional healer (MD1, 2009).

Another doctor stated that

My experience of THs has been one that they are dangerous practitioners (MD2, 2009)

A further participant expressed similar sentiments

We had a patient who passed away because he continued with TM, he ended up losing his life (MD3, 2009)

The participants also expressed concern over the possible negative interactions between ARVs and TM and therefore were overtly against simultaneous intake of the two. As one doctor pointed out

The work that's been done has shown that there are interactions so my recommendation [to a patient who has been taking TM and is on ARVs] would be to not take them simultaneously (MD4, 2009)

Furthermore, the participants referred to the secrecy around TM which makes it “difficult to know what they have up their sleeve “(MD5, 2009) as well as the problem of charlatans who are driven by profit and in turn the well being of the patient is undermined. This was seen as linked to the unregulated nature of the traditional health system whereby “anyone these days gets the calling and becomes a TH” (MD2, 2009), as one participant expressed

I think one of the problems with the traditional health sector is that it's still totally unregulated. So, as a result the THPA has not been implemented, and so anyone can open up a TH practice and start to offer treatment for HIV. And if you are desperate, very sick, and you don't believe in the biomedical sector, or you don't have the money to travel to the biomedical sector, you will go to a TH. So you have this combination, what I call the lethal cocktail, of opportunistic health practitioners and desperate patients (MD4, 2009).

This participant went on to state that

The THPA... needs to be fully implemented, and all THs need to be registered with a council, and they need to ensure that this whole industry is not full of charlatans (MD4, 2009).

Another doctor expressed similar sentiments

We need them as part of our health care delivery system... [but] not until they actually formalize their relationships, their registration. It's over to them too do that. Just like with any other profession, whether you're a lawyer, a dentist, architect, engineer, doctor... there is a bar that that you register with and your peers recognise you and you have a certificate up and you have to stay abreast of things and you abide by a code of ethics (MD6, 2009)

Another doctor also identified the problem of non-regulation

There's nothing structured enough, there's no qualifications, there's no liability issues (MD7, 2009)

What emerges quite clearly from the above is that the non-regulation of traditional healing was not only seen as problematic in terms of the existence of unscrupulous practitioners but also because traditional medicines are not subject to scrutinized testing as are allopathic medications. Indeed, this problem is also recognised in the literature on TM and its practitioners. It is explicitly mentioned that some THs engage in harmful practices as regulatory standards do not exist (UNAIDS, 2000). This issue has also been addressed in the official documentation considered above. The state has evidently acknowledged the need for the regulation of TM but the problem of implementation has been discussed above. Furthermore, the other area of concern with regard to regulation, and noted above, is that as of yet no type of policy has been developed through a consultative process with THs and regulation therefore is specified in terms of biomedical standards. According to this TM ought to be restructured in a way that suits the biomedical establishment and subject to the same kind of scientific based testing, as is allopathic medicine.

One doctor stated that

We need to have ways in which the two will coexist. But I think they need to have common elements. The WHO defined this; they need to be subject to common standards. So, all the drugs you take in the biomedical sector are registered with Medicines Control Council and they've been assessed from a safety, quality and efficacy perspective. So that you're sure that when you go and buy an aspirin it is aspirin and not salt, that it is safe and that it is going to treat your headache. We've talked a lot about the registration of ATM but we've never done anything. And that's incredibly important, you've got to subject the traditional sector to the same set of quality standards (MD4, 2009)

Another doctor expressed similar sentiments

If they [THs] would come under the same umbrella as we did then I would be more accepting of it (MD2, 2009)

As another doctor submitted

As a scientist I think things must be evidence based, and a single anecdote doesn't make it provable (MD5, 2009).

The need for evidence based testing was noted by more of the participants

I still think that the role of the state should be to try and promote the evidence based scientific agenda for the treatment of people, just to protect them. I'm not convinced that a vast majority of medicine, including westernized, subscribes to that. But evidence based medicine to protect patients as much as possible, so that they don't waste their money, waste their time, get exposed to harm (MD8, 2009)

Everything that comes out of the WHO has to be looked at in terms of how evidence-based it is, what studies support it, is it just expert opinion (which could be what THs are), what is it based on, and, you know, the best thing is something that is truly evidence based with enough good randomized control trials (MD4, 2009).

A further reason why THs were viewed in a negative light was based on the perceived ignorance within the traditional health care sector

Our work with THs has shown that there's still a great deal of ignorance within the sector, there's not a proper understanding of HIV, there's not a proper understanding of how to treat HIV or how to guide patients so that they get better. And consequently, the present situation is mostly a situation of which the two sectors are at odds with each other (MD4, 2009)

Because of this perception on behalf of medical doctors towards THs most doctors only see the possibility of any type of collaboration existing on condition that the THs are further trained and educated, especially on issues if HIV/AIDS. Interestingly, some of the participants in fact viewed collaboration as the further training and education of THs. As some of the doctors stated

We should be focused on training programmes [as part of collaboration] (MD9, 2009)

THs can provide a huge role, I think, in being able to provide patient care and guidance for a range of indications including HIV. But that has to be on the basis of further education (MD4, 2009).

They (THs) have a lot to learn and they would also be able, once they have learned you know, they would be able to help us (MD1, 2009)

I would want THs to be educated about HIV, I would want them to understand the issues, I think that is really important but working together, directly with a practitioners, I don't know, I even have a problem working with homeopaths (MD2, 2009)

It is evident that many negative perceptions exist on behalf of medical doctors towards THs. These perceptions are consistent with the literature that suggests that THs are often viewed as lacking knowledge and engaging in harmful practices that also cause delays in referrals to biomedical facilities (UNAIDS, 2000). One of the main concerns shared by all the participants, and also found in the literature is that

monitoring and regulation of the traditional health system is non-existent and results in a number of unscrupulous traditional health practitioners prescribing medication which has not undergone scientific based testing (UNAIDS, 2000). Due to these perceived downfalls of TM some of the participants were very skeptical of any type of collaboration occurring while others saw the potential for collaboration, in terms of greater communication and closer working relationships, but only on the basis of regulation of the traditional health system as well as the further education and training of THs. The type of education and training envisioned, however, is one that complies with biomedical standards and therefore is based on restructuring TM in a way that is both determined by and suited to the biomedical paradigm.

Many of the views of the participants were based on experiences with their patients however only a minority of the participants had had any meaningful interaction with a TH.

It is in fact, interesting to note that those who had interacted with THs on an ongoing basis held slightly different and more positive views. While they expressed concern about the unregulated nature of the traditional health care system as well as the harmful practices employed by a number of healers, they also recognized that some of the healers have progressed in terms of their level of knowledge of HIV. One of the participants stated

If you sit down and listen to some of them, there is great insight into HIV.

This highlights the fact that, as shown in the literature, there has been very little action on behalf of the biomedical sector to actually work with THs but that many THs in fact no longer hold the erroneous views of the past (Wrefford and Esser, 2008: 22).

From the interviews conducted it can be seen that the reason doctors are wary of interacting with THs is embedded in the many negative perceptions of the traditional health sector. However, those that have engaged in a more meaningful way with THs have developed greater understanding of the sector and hold views that differ slightly to those who have not engaged with THs. From this it can be inferred that perhaps the starting point for collaboration rests upon the willingness of the medical establishment to take the first step forward and attempt to begin interaction with THs. However,

even those participants who have been involved in interactive programmes with THs assert that true coexistence can only occur once regulation and training is underway.

This unanimous and persistent emphasis on the need for regulations and training of THs as a prerequisite for any sort of collaboration raises the question of what type of regulation and training is envisioned and whether such is in fact possible.

Based on the interviews, it is clear that the type of regulation envisioned is dependent on a biomedical understanding of health and disease emulating western-modern professional health structures. The participants made reference to the need for registration, certification as well as a code of ethics and other standards of conventional professionalism (Kalble, 2005). In this way western standards of regulation are imposed onto the traditional health sector, as shown in the literature (UNAIDS, 2000). This demonstrates the unequal power relations that exist between biomedical and other forms of health care. Devenish (2005) shows that in South Africa the professional structure of biomedicine has enabled this healing system to dominate over other types of health care practices. This may be a significant obstacle to collaboration as authors like Kaptchuk and Miller (2005) submit that regulatory mechanism imposed by western standards may not be appropriate for controlling traditional healing because it is governed by a different belief system and understanding of health and illness. This of course will be explored further in subsequent chapters

An alternative solution is to support the THs in establishing their own registering bodies and regulation mechanisms, a one of the doctors stated

It's over to them to do that [formalize their relationships and their registration]
(MD8, 2009)

However, even if THs are left to their own devices the type of regulation that is expected to emerge, and the one that would be accepted by medical doctors is one that complies with Western standards. The problems of this scenario were pointed out by some of the doctors. While one doctor asserted that there is a need for the THs “*to be registered with a council*” (MD4, 2009) he continued to say

In some ways it's actually not regulated but in some ways it's actually highly organized and so, you're dealing here with quite a strong organized sector who will resist any attempt to undermine their income base (MD4, 2009).

Another doctor said

How do you tell the one that they're doing right and the other they're doing wrong?...how do you get a group like sangomas, and inyangas and everyone to stand together to agree upon themselves how they're going to register themselves? I worry that we're taking a Western model and we're trying to get our heads around trying to regulate them in a way that suits us and not that makes sense to them (MD8, 2009).

This participant demonstrates that there is an awareness of the need to allow the THs to find ways of regulating themselves but in the same breath suggests that this is not in fact possible, especially when western standards of regulation continue to prevail. An important point that this doctor makes is that difficulty exists in getting THs to stand together as they are not a homogenous group, and are in fact often misperceived and misunderstood as such. This heterogeneity was evident in the interviews I conducted with the THs and will be addressed in more detail in the chapters to follow.

The comments of MD8 show that there is a perception that THs will resist any attempt at regulation, as it will inevitably result in some healers no longer being allowed to practice. This is related to issues of competition between THs themselves. As Dickinson points out, THs are often in competition with one another because entry into traditional healing is not limited (2008: 284). Because of this competition there is great secrecy within the traditional healing system, as expressed by one of the doctor earlier, and this in turn makes regulation very difficult as there does not exist a shared system of knowledge to which practitioners can refer (Dickinson, 2008).

The need for a single shared repository of knowledge in order for regulation to occur demonstrates, once again, a western understanding of regulation and professionalism. This is directly related to the policy issues discussed in the previous chapter, whereby legislation dealing with TM is often about restructuring TM in a way that suits the biomedical paradigm (MediaGlobal, 2008) and in turn this constitutes a barrier to collaboration as THs may be opposed to this. However, if regulation is left up to THs

themselves it will more than likely not be accepted by the medical establishment as it will not meet the standards of such and will in turn also serve as an additional hindering factor to collaboration.

This problematic area, highlighted above, will be further considered in the analysis of responses on behalf of the THs interviewed in this study. Furthermore, the issue of resistance on behalf of THs if regulation is imposed is used by the doctors as proof that regulation and hence collaboration is almost impossible. However, we should bear in mind that simply because something is expected to meet with resistance does not mean that it cannot ultimately be achieved under appropriate circumstances.

There is no doubt that the need for regulation, as expressed by the doctors, is necessary not only in terms of eradicating unscrupulous practitioners but also to ensure that traditional medications are subject to scrutinized scientific testing. The need for traditional medications to be subject to the same standards as allopathic drugs is based on the paradigm of the biomedical model of health and illness that governs the medical realm, as well as western society. As one doctor pointed out

There's Dr X's model and there's Sangoma X's model, which are so divergent that Dr X's one is the paradigm that's living at the moment because Dr X operates through a western model, which is what the government operates in.

The views on behalf of the doctors interviewed are consistent with the literature, which suggests that power is conferred upon health professionals in order to define health and illness as well as the appropriate treatment procedure (Gilbert, Selikow and Walker, 2002; Turner, 1995). Medication therefore is only viewed as effective if it addresses the specific lesion (Armstrong, 2002) and is subject to objective scientific testing.

The problems that doctors have with actual medication prescribed by THs is therefore based on this biomedical perspective and, as Coutler shows, any alternative treatments would only be accepted if they were subject to these same methods of scientific-based testing (Coutler, 2004). One of the doctors did state that

You need evidence of the fact that the medicine works. The only argument that really holds water for me is the fact that different people respond differently to medicine. That's also a problem in the biomedical sector where you do a clinical trial you'll never ever get 100% effectiveness, there's always someone who hasn't had this drug reaction... the traditional practitioners argue that their approach is totally personal therefore the idea of trials is not appropriate. Because they use different combinations depending on the person. So, that's fine, I don't have a problem with that but then show me the evidence that it makes people better... Different things work for different people, and the biomedical sector is slowly beginning to understand that, at an evidence based level (MD4, 2009).

Initially it seems that this doctor acknowledges the existence of personalized medicine and the problems with scientific based testing. However, ultimately he also falls within the biomedical paradigm and expects personalized medicine to be evidence based if it is to be accepted, and overlooks the importance of immediate and personal experiences that is fundamental within the CAM paradigm in proving efficacy of treatment (Kaptchuk & Miller, 2005).

The problem with this is, as Coutler (2004) further argues, is that to force alternative treatments, in this case TM, to be assessed according to biomedical standards is to accept one form of knowledge over another and to promote the dominance of the epistemological basis of allopathic medicine, and essentially a western world view.

This explanation is also related to the type of policy that exists in order to restructure TM in a way that suits the biomedical paradigm and may be contrary to the belief system embedded in traditional healing. Furthermore, as Mall (2005) notes, although many doctors agree that collaboration with THs is necessary they advocate this only under a hierarchical system whereby biomedicine holds priority).

What emerges, quite clearly is that one of the main problems that exist is the inability of medical doctors to think beyond the biomedical perspective they have been professionalized and trained in. This was noted by some of the doctors themselves. As aptly expressed by one of them

The whole thinking [of doctors] is in a scientific paradigm and that is how we work (MD10, 2009)

Another participant said that

I am afraid I am very conventional; I am very much this is how it has to work (MD5, 2009)

Others shared this opinion

I don't know what they [THs] are basing their practice on, they could also do harm, but that is my very conventional bias (MD2, 2009).

This doctor, however, also admitted his limitations by stating that

I am very closed minded (MD2, 2009)

This inability of medical doctors to move beyond thinking within a biomedical perspective constitutes an obstacle to collaboration as it prevents a true understanding of TM as meaningful method of treatment and care. Furthermore, it raises the question of whether THs would be open to such 'biomedical' reformations. This position on behalf of THs will be further explored subsequently.

The dominance of the biomedical perspective is also evident in the type of training envisioned by the doctors for the THs. As indicated earlier, a further condition for any type of collaboration is the education and training of THs, and many in fact saw the running of training workshops themselves as constituting a form of collaboration. The type of training and education that was proposed by a majority of the doctors interviewed, however, was focused on improving the knowledge of the THs, specifically with regard to HIV/AIDS, according to biomedical understandings, as one doctor stated "*they have a lot to learn from doctors*" (MD1, 2009). When asked whether they thought they would have anything to learn from THs, the majority of the doctors found the question amusing. This demonstrates, once again, the superiority on behalf of medical doctors in relation to THs and the way in which the role of latter is not considered in a genuine light by the former. This in turn undermines collaborative

efforts as respect for THs is evidently lacking. However, after further probing some of the doctors agreed that if there was greater dialogue between the two realms they might hold different opinions

I am very closed minded, but that can change, maybe if we could sit and talk (MD2, 2009).

This comment confirms the need for mutual engagement to occur between THs and medical doctors. In order for this to prove successful a genuine willingness to engage needs to exist on both sides. This is evidently lacking and therefore, as discussed in the policy section above and to be considered in more depth below, the state ought to be more active in driving these initiatives and setting mandatory standards for collaboration to occur.

As alluded to already, the doctors, who had been in interaction with THs held a somewhat different view. This specific group of doctors that were interviewed in this study, had run training programmes for THs in KZN, as the one doctor explained

The first initiatives in KZN were sponsored by universities to go and teach them how to protect themselves from AIDS and other blood born conditions because they were dying there. And they were illiterate, so there were programmes where we actually taught them about HIV using different methods, so they would understand the syptomology. So the initial initiatives were to try and save them, the current initiatives are to try and engage them (MD6, 2009)

This doctor went on to say that

Exchange of knowledge [is important], we can learn from each other because no treating doctor is so arrogant that they say I know everything, they realize they need a multidisciplinary team (MD6, 2009).

However, it was evident that most of the doctors interviewed did not share this opinion. Furthermore, even while this particular group saw exchange of information as beneficial they advocated this only once training of THs according to biomedical standards had occurred.

This further validates the existing problems, discussed earlier, of the uneven and asymmetric power relations between the two paradigms, the devaluation of alternative health care knowledge as well the hierarchical nature of biomedicine even within collaborative efforts (Coutler, 2004; Mall, 2005).

As another doctor clearly articulated

I actually think to say that what we do with this is an educational response I think is actually to view the whole problem through a biomedical lens, and the one thing you can't do when you acknowledge medical pluralism is to view health care through a biomedical lens. Because the problem is, actually that's sort of an anathema to the whole concept of pluralism (MD11, 2009).

While this participant makes a valid point, and highlights many of the issues that have already been discussed the problem is not with education per se but rather when the educational process is viewed as one sided, and as a means to enlighten the THs and bring them up-to-date with biomedical knowledge. However, if an ideal situation could emerge whereby mutual engagement and learning were to occur, this type of an educational response would not undermine medical pluralism, but would rather facilitate its coexistence. This issue also needs to be addressed further when considering the position on behalf of THs.

Up until now I have considered how many of the views held by medical doctors are problematic in that they are dominated by the biomedical paradigm. I have, thus tried to challenge this way of thinking by arguing that a shift and more openness in this type of thinking may be beneficial in facilitating some degree of collaboration. One area, however, where it is not possible to dispute the doctors is on the negative interaction between TM and ARVs, as articulated

The work that's been done has shown that there are interactions so my recommendation [to a patient who has been taking TM and is on ARVs] would be to not take them simultaneously (MD4, 2009).

All participants agreed that simultaneous intake of TM and ARVs is dangerous and they would recommend that their patients did not adhere to such practices.

My general advising [to patients] is to say that we don't know how ART and TM work together so you have got to pretty much decide on which one you are going to follow, there are drug interactions with ARVs and we don't know generally even what is in TM and what reaction it is going to have (MD8, 2009)

While one of benefits of CAM, as illustrated in the literature, is that it can be used in conjunction with allopathic treatments as it does not interfere (Stratton and McGivern-Snofsky, 2008:3), this is not always the case with TM as there have been documented cases of negative interactions occurring between TM and ARVs (The Sunday Independent, 2005). This serves as a major barrier to collaboration for two reasons. Firstly, it gives doctors legitimate reasons to be wary of TM and suspicious of THs and secondly, it is unlikely that THs would support a position whereby they advocate ARVs without and instead of TM. This of course will be further addressed in the chapters dealing with the views on behalf of THs

Nevertheless, the point must also be made that although some traditional medications may interact negatively with ARVs this does not necessarily mean it is the case with all of them. However, in order to assess this in a way that would be acceptable to doctors TM would have to be subject to scientific based testing and this, once again, highlights the problems that have been discussed already

Perhaps if an ideal scenario of mutual learning and education was to be established this would pave the way for both sides to learn about the respective treatments and the way in which they interact. The position on behalf of doctors, towards mutual learning is very skeptical and while many eventually agreed with the position I took that increased communication between the two sectors may be beneficial, most admitted that they would not initiate this kind of dialogue but would engage only if they had no choice, as one participant asserted

I would never initiate it (communication); it would have to be law before I would do it (MD2, 2009)

This clearly points to the need, as examined above, for government intervention in promoting collaborative efforts between the two sectors and setting the necessary obligatory standards in this regard. The limitations of current official policy on the matter must therefore be addressed if a collaborative environment is to be fostered.

“Traditional Psychologists”

Although many negative views were revealed on behalf of the doctors towards THs, there was also some recognition of the benefits provided by these practitioners. All the doctors admitted that they are aware that a large percentage of their patients consult THs, as stated

They’re such a large component of my patients’ care (MD8, 2009)

Or as indicated by another doctor

They are recognised by the communities (MD9, 2009)

And

People still believe a lot in TM (MD1, 2009).

Most of the doctors attempted to explain in it by focusing on the observation/fact that THs offer many things to their patients that allopathic practitioners do not. These benefits were mostly understood in terms of THs being culturally connected to patients and more accessible than allopathic practitioners and their treatment. As can be seen from the statement that

THs fit the cultural context [of the patients] (MD7, 2009)

Furthermore, reference was made to the holistic nature of traditional healing as another reason for their demand and use by patients, as reflected in the following quote:

With HIV... it’s not just about medicine itself because if you can’t get behaviour change and all that you’re not going to be successful in your treatment outcome. So therefore when it comes to recognising the need of people we need to understand about their treatment and the resources they going to use. It’s all about a holistic approach towards the patient outcome. (MD9, 2009)

Or as articulated by another doctor

What I've seen in the traditional health sector is that these are generally health practitioners who have a better understanding of the cultural context of their patients, who are able to spend more time with their patients, who are more accessible, they not hidden by layers of the kind of biomedical sector hierarchies, and the barriers that are present. If you got to a hospital the first barrier is where is the hospital, the second barrier is the queue is half way round the block, you've got to take a day off to go. So all of those issues. So, THs have an important position in the overall totality of health care (MD4, 2009)

This doctor even explicitly stated that

The one (TM) fills an important gap, which is not present in the biomedical sector (MD4, 2009).

Another doctor corroborated this position

They play a role that we can't fulfill (MD3, 2009)

These views are consistent with those of Muller and Steyn (1999), as well as Peltzer and Mngqundaniso (2008) who argue and demonstrate that African traditional healing is physically, socially and culturally more available than allopathic treatment and offers treatments that are more holistic in nature and for this reason are accepted widely by the African communities. Because of this, many of the participants saw THs as having an important role to play in prevention of HIV/AIDS. It is clear that there was recognition on behalf of the participants that certain gaps exist within the biomedical sector in the South African context. The literature explains some of these gaps in terms of medical doctors being culturally distant from patients as well as the limited number of human resources within the medical sector (Cook, 2009; Peltzer and Mngqundanison, 2008). The inclusion of THs in HIV/AIDS prevention and treatment strategies would, as indicated in the literature, benefit the medical sector as it would contribute to expanding the reach and efficacy of these strategies (Richter, 2003)

However, there was concern, as already indicated that THs lack the right kind of knowledge in order to promote prevention of the disease, as noted

On issues like prevention, you shouldn't have to go to a doctor to be told to use a condom; this is something that THs should be advocating. Because, if they represent the interests of their patients that's what they would do. But you get some practitioners who don't, and say that condoms are the reason we have HIV, and I think it's totally shocking (MD4, 2009)

This view is consistent with the literature, which shows that many THs are regarded as lacking physiological and anatomical knowledge (UNAIDS, 2000:11). However, as Wreford and Esser point out, while in the past many THs held erroneous beliefs about HIV/AIDS, this is not always the case today and this issue will be addressed further below.

The fact that some of the doctors admitted that the biomedical sector has gaps that the traditional health sector could fill points towards the possibility of, and the need for some degree of collaboration. However, according to the doctors, this would remain conditional on regulation and training, as discussed above.

Of interest to note is that there were two areas that were seen as sites where THs may have a role to play without further training as a precondition. The first was in the asymptomatic stage of HIV/AIDS and the second, the chronic phase. As can be deduced from the quote below

I think there's a role for herbal medicines in the asymptomatic period of the disease, or the chronic period of the disease (MD4, 2009)

While the abovementioned beneficial aspects of the traditional health care sector were generally acknowledged by most of the participants, one area was unanimously considered to be the primary contribution towards health care on behalf of THs. This was the area of psycho-social support, which is of course linked to the benefits mentioned above. As one of the doctors articulated

Most of our people still believe a lot in ancestors and all that, so psychologically I think they offer the patients a lot...the TH emphasizes the relationship between the person and the ancestry, so definitely psychologically they help (MD1, 2009)

Another doctor said that

The biggest benefit would be on the psychosocial plane (MD7, 2009)

Others shared this opinion

There may be more of a psychology use, there may be a role of how people view disease, and there may be a role in how they decide to take or not to take their medicines. But that's like, I am the doctor and then I have got a psychologist, and then I have got a dietician and then I have got a physio and we all have our own roles. But I am not the doctor working hand in hand with another doctor... (MD5, 2009).

This doctor went on to say

If they were traditional psychologists I have no problem with that (MD5, 2009)

These sentiments are evident in other interviews

I have no problem with the psychological side of things, where people are explained to in their cultural context, I often think that brings quite a lot of mental relief for people. I see a lot of stress in my patients, people who are very distressed... there might be a role there. If that were all they were doing, like in a western context I would send them to a psychologist (MD8, 2009)

From my level I see that the THs actually support all psychosocial treatments, even though they do give herbs and all that it's more about, for the patient, about talking and somebody that's listening to them, which they don't find outside. So I don't really see that it's just the medicine itself that's helping, especially from the spiritual side. These people are very strong in their spiritual belief and having to talk to a TH who can advice them on things to try out, it's a very interesting thing but I think definitely

when it comes to the support but the medicine side, there should be very careful (MD9, 2009)

It is apparent that the participants did recognize the role of THs as extending beyond the prescription of traditional medications, the problems of which have been discussed above. The psychosocial role of THs was therefore recognized as an important aspect of patient care and the potential for collaboration in terms of cross referral was noted. However, this potential was, once again, is conditional to regulation and further training according to biomedical standards, as clearly argued by one of the doctors

Let's say in that case [of a patient needing psychological support as well] you refer the patient to a psychologist who is registered with the South African Professional Association. I can't say to you but I think you should go to that guy standing on the corner next to the garage and get some of his herbal medicines. That's the problem; the sector's got a long way to go before we can get to that situation, where you can refer a patient to someone who is registered (MD4, 2009).

Another doctor shared this opinion

If we can give them a basic training in some counseling skills, that will be good so that they can realize this is the situation and then refer from then on to more experienced staff, because then we will stop them from doing harm instead of doing good (MD3, 2009).

It can be concluded therefore, that even though the positive roles of traditional healing are acknowledged by doctors and even if those positive aspects are distinguished from the actual medications given, a biomedical superiority continues to exist whereby the psychosocial role on behalf of THs would only truly be accepted if THs complied with biomedical standards. In this way, even this psychosocial role is not seen as truly positive as it currently exists. This, once again, reiterates the point illustrated by Mall (2005) that collaborative efforts are only advocated by allopathic practitioners according to a system whereby biomedicine hold priority. Furthermore, adapting the psychosocial role on behalf of THs according to biomedical standards would undoubtedly constitute, as expressed in the literature, a restructuring of an essential

component of TM in a way that is completely contradictory to the central belief embedded in traditional healing (MediaGlobal, 2008). A significant aspect of this psychosocial role, as Muller and Steyn (1999) highlight relies on a connection with the ancestral realm and the establishment of supernatural causes. This cannot be governed by a biomedical structure and eradicating, or even refining this aspect would undoubtedly result in many of the benefits of traditional healing (such as cultural connectedness with patients) dissipating, which in turn would undermine the ability of THs to potentially fill some of the gaps present in the medical system.

Furthermore, even if this psychosocial benefit of traditional healing is accepted as it currently exists the proposed shift or reallocation in the role of THs to simply “traditional psychologists” constitutes, once again, a virtual dismantling of the traditional health care sector and a relegation of THs to simply auxiliaries to the doctors fulfilling different functions that they are not able or not willing to make an effort to fulfill.

This in turn is contradictory to the benefits noted above of THs as providing treatment that is holistic in nature and would undoubtedly be met with great resistance by any TH.

While there are some THs today who practice as only Inyangas and do not administer herbal remedies, many THs, as noted in the literature, incorporate both practices of ancestral communication as well as administration of herbs, and both components are as important to the practice of traditional healing (Kale, 1995; Cook, 2009). This was also evident in the interviews conducted with the THs as they all practiced as both Sangomas and Inyangas. This proposition, by the doctors interviewed, that THs assume the position of “traditional psychologists” instead would most likely not be a viable solution. In addition, it is likely that ‘western psychologists’ would oppose this proposition as vehemently as doctors oppose affording equal status to THs as medical practitioners. This is made clear in an article by Holland who documented the benefits offered by sangomas as the “psychologists of Africa” but showed that “conventional shrinks...believe that their own mental health worldview is the valid one (The Star, January 25 2010).

To collaborate or not to collaborate?

It is obvious that many negative views exist on behalf of medical doctors towards THs and even though the benefits of traditional healing are acknowledged, they are mostly seen as problematic in some regard and in need of ‘biomedical reformations’. However, because traditional healing continues to be used by a large number of patients and its capability to fill some of the gaps present in biomedicine, some sort of collaboration was seen as potentially beneficial by many of the doctors. However, the problems associated with this were always highlighted

The paradigms are so totally different, I don't know how you marry these two (MD5, 2009).

One doctor referred to collaboration as pointless

The philosophical approaches are so different that to encourage collaboration is a weird thing. It's a bit like saying... cross collaboration between such different philosophies... I sometimes wonder whether it's actually that useful to actually try it. (MD8, 2009).

Those who agreed that a degree of collaboration was necessary advocated this only under a system whereby biomedicine continues to dominate in that further education and training of THs, as well as regulation of the sector take place according to biomedical standards, as the prerequisite to any mutual activities. As indicated earlier, some of the doctors in fact saw the training and education of THs as constituting a form of collaboration. This training was seen by most as one sided and a way to educate the THs but not to learn from them.

Only a minority saw training workshops as a potential to encourage mutual learning between the two paradigms. Those who were supportive of this were the ones who had actually been in contact with the healers while the other doctors had had limited or no contact at all with a TH. Some of the participants saw the potential for further collaboration once THs had been educated and trained according to biomedical perspectives. The type of further collaboration, however, was viewed as a way of essentially using THs to support biomedical initiatives and increase accessibility to

patients and in this way, essentially to relegate THs to biomedical assistants. As one participant submitted

I'm using my western paradigm to provide my western treatment through a cultural thing. That's very useful, it's a means to an end, it's not working with them, I'm using them as what's effective to get to my patient. To try and pretend that's somehow a mutually beneficial relationship actually obscures the fact that I'm still there operating in my context. (MD8, 2009).

Most of the participants did view increased communication between the two sectors as beneficial, and many saw this as the only viable option to collaboration. There were, however, views expressed that such communication would not be initiated unless it was legally required of them.

The fact that the willingness by some doctors to communicate with THs would only be possible under legal conditions that forced them to do so is of crucial importance in this context. It clearly calls for government intervention in areas of potential collaboration. However, there are many problems associated with the current official policy on TM as discussed earlier.

It can therefore be concluded that collaboration, according to the doctors interviewed, would only be accepted if THs become more 'biomedical' or western in their approach. One can assume that this would not facilitate collaboration, as it would undermine the traditional health care sector. Whether this is the case, and how to overcome it will be dealt with further in the following chapter.

There were, however, two interesting perceptions on behalf of the doctors towards collaboration that emerged from the interviews. The one was that THs do not acknowledge any benefit in biomedicine and would not be interested in working with medical doctors. As the one doctor expressed

He [TH] doesn't even think I have anything to contribute...they [THs] regard me as an unnecessary evil (MD8, 2009).

Another doctor shared a similar view

It will certainly be easier to get doctors to work with THs than to get THs to work with doctors (MD6, 2009)

This perception serves as another potential barrier to collaboration as it prevents doctors from initiating contact with THs whom they believe also do not want to establish connections. Perhaps, however, this is simply a justification on behalf of the doctors so as to shift the blame for lack of collaboration onto the THs.

This perception is related to another view that emerged from the interviews. Many of the participants mentioned that the THs whom doctors are able to make contact with are the ones who choose to be seen, and are more open to western thinking but are the minority group, as one doctor stated

The THs we see are the ones who choose to be seen, and it's probably the minority of THs. (MD8, 2009)

This implies, therefore, that any real collaboration, with THs as a whole, is unrealistic, as they hold negative views towards biomedicine and would not be open to collaboration. The question that must be asked, however, is whether this is really the case and if it is, does this mean that any sort of collaboration cannot occur even if it is merely with the minority? The implications of this may be great in that if it is simply the minority who will join collaborative efforts what results will emerge for the majority? Will they strongly resist any collaborative efforts and in so doing sabotage connections between THs and medical doctors? Or will they be driven underground and continue to exist as they do but even further out of sight of western society, even if appropriate and effective legislation is developed.

Alternatively, perhaps if communication is initiated even with those who potentially hold negative views their perceptions may change, as is the hope with many doctors who currently do not believe traditional healing has anything to offer.

One of the participants did however offer a different outlook to the one above

There are a lot of THs who actually want to deal with this issue. There are some who are just there to make money, but there are some who are really interested in the welfare of their patients and will do what's necessary. So, those are the people that one has to work with. (MD4, 2009)

This doctor makes an important point, that although there are THs who would not be open to collaboration there are many who have their patients' best interest at heart and would therefore be open to working with doctors if it were in the patients' best interests.

It would be fallacious to assume that collaboration could be fostered with all THs, just as it would not be possible with all medical doctors. But simply because some will be against it does not mean that collaboration should be neglected or that it could not work with those who are open to it. As the Valley Trust example in the literature shows, collaborative efforts can be successful with those healers and doctors who are acknowledge what the other offers. Furthermore, as stated above, if communication was initiated between healers and doctors this may result in a number of healers and doctors changing their views and may pave the way for a more collaborative environment to emerge.

THE TRADITIONAL HEALERS' PERSPECTIVE

From the interviews conducted with the THs it is apparent that a number of differences of opinion exist among the THs themselves, highlighting the fact discussed earlier that they are not a homogenous group. However, similar views emerged with regard to many of the issues put forward in the interviews. Both, the differences as well as the similarities are considered below.

Psycho-Social Practitioners

The THs confirmed that a large number of HIV/AIDS patients are consulting them and that broader social factors are taken into account when diagnosing a patient. These factors however, are inextricably linked to the ancestral realm, which is viewed as essential in understanding the broader social dilemmas, as one healer explained

The bones tell us in the family they are quarrelling, this is why there is an evil spirit lingering, because it started with your grandfathers and the evil spirit hasn't been broken because it's still carrying on from generation, there is a curse. We do that first. But it's more holistic. In order for you to be healed you need to discard the evil spirit or someone in the family is busy doing this. This is why we have to go back to the ancestors, so that things can be healed. There are other pre-performance before the treatment (TH1, 2009).

Another healer added that

One of the things we discuss a lot is the emotional support around them

She went on to say that

One of the things that I think is underrated about visiting a TH is that you spend a lot of time talking and counseling (TH2, 2009)

For the THs, the throwing of the bones is essential in that communication with the ancestors allows them to reveal the reasons behind the cause of the illness. These causes are often linked to interpersonal relationships within families and within the community as a whole. In this way THs can be seen as operating within the PSE model, as shown in the literature, where disease is seen not simply a result of a pathogen but linked to broader factors (Gilbert, Selikow and Walker, 2000: 5). Furthermore, patients are able to enter an environment where they are given time to talk and connect with the THs and in this way traditional healing offers something that biomedicine does not. This connection with the healer is possible both because of the available time as well as the way in which healers are able to identify with their patients as they are more culturally connected, as one of the healers noted

It's only us who understand the sickness of the person (TH3, 2009).

What this healer meant is that disease can only be understood by referring to broader factors, and it is only through contact with the ancestral realm that these other factors are revealed.

These views are consistent with those of the medical doctors, as well as the literature, identifying THs as culturally and socially more available than allopathic practitioners (Muller and Steyn, 1999); Peltzer and Mngqundaniso, 2008) and shows that THs practice is in-line with the PSE model of health and disease. Because of this, THs are able to fill many of the gaps present in biomedicine and collaboration would therefore be beneficial to the patient.

The psychological support that was acknowledged by the doctors as one of the benefits of traditional healing was confirmed by the THs interviewed as they stated that much time is spent talking and counseling with the patient. This personal connection with the patient often allows the patient to feel comfortable about disclosing their HIV status and discussing private matters with the TH. As indicated by one of the healers

Even before you do the actual diagnosis, whichever method you're going to use, you find people will tell you: You the first person I'm telling, I've been walking around with this for the past 3 years... all of the people that I've seen, even if they haven't come in saying I'm HIV positive, have left and we've had a conversation about the status... you can't force [people to] disclose but you need somebody that you can talk to (TH2, 2009).

This healer also said that

One of the things we discuss a lot is the emotional support around them, because it's such a huge burden to walk around with this thing eating at you. So what I try and do always, I emphasize that it's manageable

This was confirmed by another

Before we treat a patient, we put them psychologically in that mindset (TH4)

Another healer also stated that

You have so many people who say they cannot go and talk to a psychologist but they'll come and talk to me. (TH5)

It is therefore clear that the treatment protocol on behalf of THs is consistent with other types of CAM in that the mind body and soul are all addressed (Stratton and McGivern-Snofsky, 2008).

With regard to HIV/AIDS the psychological support offered by the THs is even more beneficial as it addresses the area of stigma and secrecy around disclosure of status. While many infected individuals struggle to disclose their positive status, traditional healing offers the necessary support in order to enable patients to feel comfortable about discussing their status. Stigma, as shown in the literature, is one of the factors that have contributed significantly to the spread of the disease (Parker and Aggleton, 2003). It is obvious that doctors are not very successful in addressing this area, as stigma and non-disclosure of HIV status remains a severe issue in South Africa, and THs therefore have the potential to address this gap within the medical sector if collaboration is fostered. This is because collaboration would enable THs to have even greater access to HIV infected patients. In addition, by including the healers in HIV/AIDS response programmes from the outset they would add a desperately needed component to them, which would potentially address issues of stigma and enable those infected to feel more comfortable disclosing their status and seeking the necessary treatment.

Giving up or Regulating the Herbs?

The recommendation that THs be relegated to “traditional psychologists”, under the condition of additional training, was not welcomed by the THs interviewed. While one of the participants did state that further training in counseling would be beneficial, none accepted the proposed relegation on behalf of the doctors. The perception by the healers was that the different components of traditional healing were not separable, as expressed by some of the healers

We cannot heal without herbs; it goes together with ancestors guiding them. There are prophets like in the Old Testament but with traditional healing it always goes with herbs, so it needs to go together (TH1, 2009)

They (the herbs and the spiritual/psychological component) are both as important (TH3, 2009).

According to these THs, the psychological aspect is simply one component of traditional healing but the herbal remedies are as important and would therefore not be given up.

While many doctors see this as a prerequisite to any collaboration it is clearly unrealistic and therefore both doctors and THs would have to come to an agreement about the type of herbal remedies used. This would only be possible if communication between the two paradigms was enhanced and further developed.

The other recommendation, on behalf of the doctors, that TM be used only in the asymptomatic and chronic phase was also not accepted by the majority of the healers. One participant did state that

If you are taking TM and you get to the point where your CD4 count is really low you have to decide, do you want to continue with traditional healing or take ARVS, you have to make the choice (Key Informant, 2009)

However, most of the healers agreed that TM and allopathic could be taken simultaneously

You see some people come, those that know their status usually come either because they are not yet on ARVs and want to delay it or they are on ARVs and are looking for something to add to that particular routine if they are already on something (TH2, 2009).

Another healer, when asked if TM works as a complimentary treatment with ARVs, answered

Complimentary definitely, as working with ARVs (TH4, 2009).

While one of the other healers expressed similar sentiments

If somebody comes and does tell us they have AIDS we help the patient, sometimes they have sores, some sores might be inside so we give them imbiza, that is herbal

mixture in a bottle. And that takes the inside sores out, then we refer to hospitals so that the doctors can give ARVs (TH1, 2009).

From the above it is evident that the THs interviewed are not against ARVs in any way, and in fact see this allopathic treatment as beneficial. This shows that the perception of THs as anti-ARVs does not reflect the reality and, therefore, as the literature suggests, traditional healing is not a stagnant system but evolves and nowadays is accepting of biomedical principles (Wrefford and Esser, 2008). This demonstrates that collaboration based on incorporating some biomedical practices might therefore be possible. However, it is also clear that most of the healers interviewed do not view the simultaneous intake of TM and ARVs as detrimental in any way and therefore would not collaborate on the basis of TM being replaced by ARVs when CD4 count has dropped. When asked what they thought of the negative interactions between TM and ARVs most of the participants did not believe that this was genuinely the case, as one participant argued

What I've been told is that sutherlandia interacts with ARVs. None of my products have got sutherlandia in them. So it's having gone through my medications and the possible interactions, I haven't had any side effects come back to me. Science is fine but you've got to rely on the people that come with the medications and say this is how it's making me feel better and those things. For me that's the indicator (TH2, 2009).

Another healer asserted that

We don't give a patient something that is going to harm the patient; we are giving the patient something that is going to make that patient healed. But doctors sometimes complain about dosages, even patients themselves they overdose themselves because they feel that if they want to be healed soon they should take a lot then that medication becomes poisonous (TH5, 2009).

Another participant shared this view

They say stuff is poisonous, but if used correctly, in the right doses then you shouldn't get contra indications (TH3, 2009)

While the one healer does make an important point in that sometimes patients may sabotage their own treatment and it is not possible to control what the patient himself does the fact that the healers do not recognize the possible negative interactions between TM and ARVs is severely problematic and is undoubtedly a significant obstacle to collaboration. As seen in the analysis of the interviews conducted with the doctors, one of the concerns of TM is the negative interaction it has with allopathic treatments. The literature shows that these concerns are not unfounded as some traditional medicines have been proven to interact negatively with ARVs (The Sunday Independent, 2005). The insistence on behalf of THs that patients can continue with the administering of herbal remedies while on ARVS is therefore problematic and is an impediment to any type of authentic partnership developing between allopathic and traditional health practitioners.

However, as a key informant stated

If they (THs) were more involved (with the doctors) they would understand the negative interactions, and would accept if a patient chooses ARVs over TM (KI, 2009)

This participant demonstrates the need for further education in the area of interactions between TM and ARVs. Furthermore, as noted above, simply because some traditional medications interact negatively with ARVs, this does not necessarily mean it is the case for all of them. Therefore, if communication and interaction between THs and medical doctors were enhanced, both sides would learn from one another and would possibly be able to establish, concurrently, which TMs can be used in conjunction with ARVs. However, as demonstrated above, the type of indicators of efficacy differ for TM and allopathic treatments. This is due in part to the personalized nature of TM, as one of the participants noted

So there might be a basic formula for the immune system and then you'll add various things, depending on where their own immune system weaknesses are in addition to just overall dealing with the virus (TH2, 2009)

This personalized nature of TM was confirmed by another healer

Sometimes it's different herbs for different people (TH3, 2009)

This personalized aspect of traditional healing is beneficial in the sense that remedies are developed according to the individual are therefore more meaningful to the patient, as the literature on CAM shows (Stratton and McGivern-Snofsky, 2008). However, as discussed above, this is problematic for doctors, as medical standards of efficacy cannot apply to personalized medicine. The question is how to maintain the personalized aspect of TM while at the same time ensuring that it is accredited by doctors. This would possibly entail allopathic practitioners observing the patients on their journeys and drawing conclusions from such. This in turn would rely on establishing other criteria, independent of clinical trials, in order to determine efficacy of treatments. However, this would constitute an abandonment of a component of biomedicine and therefore may not be possible at all. Although, as was noted by one of the doctors above, even biomedicine is slowly beginning to realize the credibility of personalized medicine and therefore perhaps an appeal for the reexamination of what constitutes appropriate evidence in proving efficacy is not in fact unrealistic. Furthermore, one of the healers framed the problem of negative interactions in relation to some practicing THs who do not know the herbs well enough

In our healing we use enimas a lot, umkata. Now, there's a medication which is strong, which will make you go to the toilet quite violently and there are other ways we use it to introduce medication directly into the blood stream, which doesn't drain you as much, or dehydrate you. But if you don't know the difference you'll just prescribe and then you'll get the negative impacts. Even something to drink, you can give someone something to drink which works on regulating the system, of detox, what they call imbiza. You can get one that can make you feel like you've taken a laxative and then you can get one that just regulates you, in a gentle way. But if the person mixing these things for you does not know fully then you're going to find yourself in big trouble (TH2, 2009).

While this may not necessarily be the case that only unscrupulous THs prescribe herbs that interact negatively it points to the fact that the existence of non-bona fide practitioners is also recognized by THs themselves, as another healer confirmed

Some are just chasing money. That person will say I will heal that, even if they are not good at it (TH3, 2009).

The participants also highlighted the fact that other problems exist among THs themselves

Jealousy [is a problem] among the THs, because it's difficult if I have a patient to take him to someone else because that person will see the weakness in me and they will think I don't know how to cure and will flock to the other...but if we can learn to trust one another, and learn to know one another it will be easier (TH6, 2009).

While this justifies the negative perception on behalf of medical doctors towards THs it also demonstrates that this is not necessarily the case with regard to all healers. Many THs are not oblivious to the existence of harmful practitioners and the problems present within traditional healing. Of significance was the fact that the participants were in favour of regulation in order to eliminate these unscrupulous practitioners as well to enable a more cooperative environment among THs themselves, as noted

You can legislate that (TM), you should. Even in the old days, that whole apprenticeship was that. In the days of old I would have somebody young who's with me now, who's my apprentice from now, who by the time I die is a seasoned, well, you know, knows everything. That's not happening anymore, people go become a sangoma and all of sudden they are prescribing medications. Now there's a vacuum. So how do you bridge that gap? You've got to introduce some kind of programme which upskills people, even if it's theoretically first and then they get into the practical application. The preservation of the passing down of the knowledge is not there. Nobody can argue that yes it's still being passed down the way it was. It's not. Also, there needs to be minimum standards, that's why it's so important that we do the training. So that everybody gets to the minimum standard (TH2, 2009).

Other participants stated

We are happy for government to regulate it, and to work with government and the hospitals (TH5, 2009).

If government were to regulate we would be very happy, and especially with the further training and to learn from us (TH3, 2009)

We haven't done it before, and how to keep records and everything; we need training for this (TH4, 2009)

These remarks made by the THs are most significant in the context of this study. The literature suggests that regulation attempts impose western standards onto traditional healing and in turn will prove to be a barrier to collaboration (MediaGlobal, 2008). These same concerns were also expressed by some of the doctors and it was recommended that THs develop ways of regulating themselves. However, from the above remarks it is evident that not only are THs open to regulation by government but are in fact welcoming of it. These participants admitted that they would require help regulating the traditional health care system. This implies that if left to their own devices, attempts at regulation would more than likely fail and it is therefore essential that official assistance be given to THs in this area. This in turn would enable some collaboration, since *harmful* practitioners would be targeted and in due process eradicated. Indeed, many of the doctors did point out that resistance might follow regulation attempts. The THs also acknowledged this but, as one insightful participant stated

Yes there will be resistance, like with all things in life. But the majority will say I am open. And I base this on the people that are actually qualified sangomas (TH2, 2009).

As I have argued above, simply because something meets with resistance does not mean it is not possible. In addition, it is clear that even if it is not the case that it is the majority of healers who are interested in collaboration and regulation, there are enough healers who will be open and welcoming of such efforts. The participants did, however, express concern about not being involved in the development of regulation policies and processes. These views on behalf of the THs point towards the need for the involvement of THs in policy development and regulatory endeavors, as would be the case with any other professional group.

As mentioned in the literature, policies to regulate and institutionalize TM are developed by and written in the language of the biomedical paradigm instead of being developed by THs themselves (UNAIDS, 2006) and it is therefore not surprising that these policies do not translate into action. THs are evidently supportive of government intervention in regulating TM, and it seems that according to the opinions expressed by THs in this study they are in fact quite reluctant to establish a regulatory mechanism on their own, which is contrary to some of the literature as well as the doctors' opinions. They clearly welcome government intervention and would like to be consulted on the development of policies. Ultimately, a collaborative environment needs to be fostered in order for appropriate regulatory standards to be established and in turn for collaboration between THs and medical doctors to occur. The onus, it can be assumed, is on government to initiate this consultative process in developing appropriate policies for the institutionalization and regulation of TM. The fact that this has not happened in the last 15 years demonstrates that although political will for the recognition and regulation of TM may exist this is not sufficient in realizing the objectives. An appreciation on behalf of the state of the complexities, as they have emerged from the study, with regard to regulatory mechanisms for traditional healing is necessary if appropriate legislation is to be developed. Without such an appreciation and understanding on behalf of the state policy will be undermined, as it will inevitably be inappropriate, even in the presence of political will.

HIV/AIDS, Biomedicine and Collaboration

In addition to the views on ARVs, other perceptions with regard to HIV/AIDS and the biomedical establishment emerged from the interviews conducted. It was quite difficult to establish one set view with regard to the THs understanding of HIV/AIDS. For example, one of the healers had this to say

I tell them that if somebody tells you they can cure this it's not true, we can give you stuff that will bring down the viral load and make you feel better, bring back your appetite. But the minute you stop the medication you are going to be back to square one. So the minute you start telling people you can cure you're actually setting them up for failure (TH2, 2009).

While another participant sensibly added

You cannot kill AIDS but you can fight the virus in the blood of the patient, maybe to make that patient become a bit stronger than she was at first when she came to see you as a patient (TH3, 2009).

At the same time, an opposing view was expressed by some of the other participants when they were asked whether they could cure HIV/AIDS

Some patients do get healed but not all. We do have a history of a patients coming back to us, even after they've been to hospital (to get tested) there's no trace of the virus again...

For 6 years this boy was very sick, he had sores where, the armpits, even the private parts, where there is warmth. You couldn't sit in the same room as this boy. He came to me and I healed the sores and the disease, they couldn't find anything...like a person who had never had the disease (TH1, 2009).

When the patient is only HIV positive, before deteriorated to place I can't help him, if the patient is HIV positive I can take it away because the blood is dirtiness, the blood is dirty and it needs to be cleansed and I know what to use for that, if the person is HIV positive (TH6, 2009).

HIV is not new, it's an old disease, it's a vulnerable disease. This is not the first time it's killing so but there is the epidemic that comes with it and kills. But we know which herbs to use, some of them are no longer here some of them are (TH4, 2009).

These differences of opinion on behalf of THs with regard to HIV/AIDS demonstrate that THs are not a homogenous group and collaboration efforts therefore need to take this into account. This however may be an obstacle to collaboration as a common ground may not be possible to establish. Furthermore, while some of the literature suggest that THs have progressed in terms of their understanding of HIV/AIDS (Wreford and Esser, 2008) it is clear that many continue to believe that they are able to cure the disease and this may result in many THs assuming patients can be treated without ARVs (even though it was evident that they were not against ARVs).

This perception, of being able to cure HIV/AIDS with TM, is a potential obstacle to collaboration as it creates negativity among doctors towards THs and at the same time

possibly causes the latter to assume that biomedicine does not offer anything beyond what TM offers.

Nevertheless those participants who believed they were capable of curing the disease, as well as those who did not, were aware of the benefit in working with medical doctors, as articulated by one of them

We need integration between the hospital and us, because what we cannot treat the hospital might treat, and what the hospital cannot treat we will treat (TH3, 2009).

Or more practically by another

We can work together, no problem (TH4, 2009).

Others participants expressed similar sentiments

I understand the patients very well and I know exactly what's wrong but because the patient doesn't have strength, because she needs more blood in her, because she has lost a lot of blood, so working with the doctors would help because then they can give her blood (TH1, 2009)

When asked if they refer patients to medical clinics all but one participant said they do. These statements on behalf of these participants demonstrate that although some of them are confident in their treatment protocol to address disease, they acknowledge that biomedicine offers benefit that they cannot. This potentially means that they would be open to some collaboration and possibly to the incorporation of biomedical practices into their treatment protocol.

Based on the evidence in this study, it seems that the case is not that clear cut as suggested in the literature, and as expressed by the doctors, that THs would not be interested in collaborating, and do not believe medical doctors have anything to offer. It is my belief that this recognition (although slight) of the benefits offered by biomedicine might facilitate some sort of collaboration, but only if doctors come to see that THs are open to collaboration and cease using the reluctance on behalf of THs as an excuse to delay unwelcome collaboration.

Despite the above it is also necessary to note that some healers share the problematic sentiments highlighted by the healer who strongly stated that

I have never sent a single person to hospital, but every person I have helped has been healed (TH6, 2009)

Clearly, this participant was implying that there was no need to refer a patient to the clinic, as it would offer nothing that he could not. However, he went on to say that

If the doctors would like to work with me I would like it (TH6, 2009)

From this it seems that this healer would in fact be open to collaboration. The reasons for his opinion was not entirely clear but it seemed he wanted to work with doctors in order to have greater access to patients and so that he could enlighten some of the doctors to his practices. Ironically, this view is not very different to those of many of the doctors who saw collaboration as a way of strengthening the medical skills of THs and increasing accessibility to patients.

This shows that, as was the case with the doctors, there are those healers who are more accepting of what the respective health care system offers and those who are less accepting. The fundamental point is that among both the healers and the doctors there are individuals who acknowledge the benefits offered by the other and collaboration is therefore conceivable, albeit possibly only between these particular individuals initially.

In terms of further training and education of THs it was evident than in general most of the participants were open to this but some also had problems with it. One of the healers said that

It's (training workshops) good because we go there to learn (TH3, 2009)

While a key informant explained that

In terms of knowledge, they're not exclusive; they're very open to anything that works. If something works let's use it. That includes the biomedical understanding of HIV/AIDS. It's not that they see their training in a biomedical paradigm as a capitulation to biomedicine, they not saying we're going to forget about our training and our ancestors, we're simply going to incorporate this biomedical understanding into the way we treat (KI1, 2009).

This supports the position held by Wreford and Esser (2008) that THs are open to incorporating biomedical practices within their healing system and by doing so this does not constitute a shift away from traditional values but rather a way of evolving, and improving with the times.

One of the participants, however, stated that

I absolutely, on principle, refuse to go there (TH2, 2009).

The reason for this was twofold, as she further explained

It's not just about I'm gonna teach you how to do primary health care and then you walk out. Which is what is happening, they go for the courses and then they walk out. After that course, then what? That then what is not being addressed fully and until they start addressing it fully and equitably, then you're starting to talk, then there's an impact. After that primary health care course, then what?...and also the after service. Like we sitting here and chatting, afterwards you gonna walk out, what's gonna happen afterwards? It's the afterwards which is just not picking up enough of the slack with all of these interventions. It's the after effect, legislate all you want, come up with a beautiful proposal but what happens afterwards? (TH2, 2009).

When asked whether she thought workshops where both THs and medical doctors learn from one another would be useful she replied

That would definitely work. And you would get the support because the THs would start seeing that people are taking us seriously here, that we actually do have an impact in the community. That's more worthwhile conversation. Where the doctor is gonna say I give them this medicine which has got this, and does this. They gonna

stand up and say I give them this medicine, which contains things which do the following... That's a more constructive taking forward of knowledge (TH2, 2009).

This participant went on to say

You need constant learning and interaction with others. There are so many medicinal herbs in SA alone so there is no way you gonna know every single one of them, or even the combinations. We've got to open a knowledge sharing system on both sides, and that will start getting us to a point where we can look at each other as equals, and not just that backward thing that those people do.

This participant was addressing the issue of unequal power relations that exist between the biomedical and traditional health care sector. She expressed concern over the fact that this is not being adequately tackled in training workshops that are one sided whereby THs are informed of biomedical practices but not vice versa. She was also unimpressed with the fact that there is no follow up and feedback after the training workshops are conducted.

Other participants expressed similar concerns

There must be continuity. Even the workshops, they have them and then everyone goes, there is no report back (TH1, 2009).

There is no doubt from the above, that these two issues, of one sided training workshops as well as lack of follow up after workshops are conducted must be addressed in order to achieve collaboration.

Consistent with the literature, although many doctors see collaboration as beneficial, they advocate this only under a system whereby biomedicine holds priority. This was evident in the interviews with the doctors and it is clear that it is a concern for THs as well who see training workshops as one sided. It is also clear however, that many THs are grateful for the further training as they accept their limitations and that there are areas in which they can increase their current knowledge, and therefore, as Wreford and Esser show, THs are open to incorporating biomedical concepts into their traditional belief system (2008).

While some healers do attend these workshops it is evident that if they were structured in a way in which mutual learning and exchange of information took place more THs would be open to them and this would facilitate further collaboration. As indicated, even those doctors who hold strong positions against TM agreed that if they were forced to communicate their views might change towards collaboration.

The other problem, of lack of follow up after training workshops are conducted is problematic as it undermines any substantial form of collaboration occurring. This also demonstrates that these educational efforts, initiated in most cases by doctors, are not real and sustainable efforts at collaboration, or even a way of genuinely imparting knowledge but may simply be a case of making doctors feel good... this is undoubtedly one of the reasons collaborative efforts have, as Geminder notes, not been successful in South Africa (2008). Thus, training and educational endeavors need to be based on mutual exchange of information that is ongoing followed by monitoring and evaluation in order to assess the impact of these initiatives on collaborative efforts.

Prevention of HIV/AIDS was another area in which further training was seen as potentially beneficial. Many of the doctors did agree that THs could play more of a role in prevention strategies despite their concern that patients are only consulting THs once they are already HIV positive and not as a preventative measure. However, as stated by the healers

We see people when they are still presenting with STIs because of multiple partners... how do we keep them from becoming HIV positive... So equip them to deal with it, and equip the healers to be able to have that conversation with kids, with families... I think more workshops which are aimed at counseling and the different conversations that we need to be having in communities, presented to community workers who are these THs will be a starting point. Start equipping people with the tools to open discussions...the people who are running the HIV workshops should be giving them those tools (TH2, 2009)

This demonstrates that THs do have access people who are vulnerable to the disease but not yet infected and therefore could be playing an essential role in prevention strategies if a collaborative environment was fostered and exchange of information

was encouraged. This is significant as current prevention strategies that have focused mainly on education have not been successful whereas if THs were to be more involved perhaps the correct message would be driven home. It became apparent from the interviews that the participants were supportive of condom use, as one of the healers stated

We support condoms, and if the clinics could give them more (TH5, 2009)

However, one of the healers made an important point

But keep in mind it doesn't help me giving you a condom and leave you to use it. I need to give it to you, show you how to use it, show you how to show somebody else how to use it (TH2, 2009)

This opinion was shared by another healer

Because even with the condoms, the first time you there, you leave the community with the condoms, you go. When they are finished, then? It's the aftermarket servicing which is just not keeping up with the initial implementation (TH1, 2009)

The significance of the above is that while in the past many THs were perhaps wary of the efficacy of condom use, this is not as much the case today, as indicated by Wreford and Esser (2008). It seems that THs are potentially open to incorporating biomedical practices within their traditional belief system, contrary to what many of the doctors believed, and would promote condom use as long as there was dedication on behalf of the biomedical establishment to provide these condoms on an ongoing basis as well as the necessary training in order for THs to be equipped in advocating prevention.

This is an important point as it is clear that the THs interviewed did not see the promotion of condom use as sufficient in driving prevention but that it ought to be followed by the right type of conversations. More collaborative efforts would therefore equip THs with the appropriate tools to endorse prevention and would address many of the gaps of current prevention programmes. However, this is dependent on a necessary shift in the mindset of medical doctors who view THs as

opposed to biomedical practices, including the promotion of condom use. The way in which such a shift could occur would only be through developing communication between the two paradigms. Ultimately, it is essential that consultative processes between THs and medical doctors be developed in order for further collaboration to occur.

According to the literature and the evidence collected in this study, it seems that traditional healing, is not a stagnant system but evolves and is therefore open to incorporating many biomedical concepts with the traditional belief system, (Wreford and Esser, 2008; UNAIDS, 2000). Many THs agree that regulation of TM is necessary but only if they themselves are incorporated in developing regulatory mechanisms. Furthermore, training workshops ought to be designed that will facilitate mutual engagement, and in turn mutual respect. Some of the views, however, on behalf of THs, such as denial of interactions between ARVs and TM as well as being able to cure HIV/AIDS, may be obstacles to collaboration, as also noted in the literature (UNAIDS, 2000). However, it is hoped that through mutual engagement this may be overcome. Alternatively, if this is not possible, some sort of agreement could be reached to disagree in certain areas but this must not interfere with the potential for collaboration in other areas.

GENERAL DISCUSSION

This study demonstrates that the THs interviewed practice within the paradigm of the PSE model of health and illness as they address broader sociocultural, as well as spiritual, aspects when dealing with disease. In addition, they offer remedies that are personalized as well as an environment for the patient in which he is able to talk openly about matters like HIV status. It is clear from the interviews that THs, as acknowledged by the doctors and the literature, are socially, physically and culturally more available than allopathic treatment. Because of this THs have the potential to fill many of the gaps that exist in the current allopathic medical system. Therefore, some degree of collaboration is most desirable and should be fostered

Collaboration, however, cannot occur, as proposed by the doctors, on the basis of the medicinal component being given up by THs in favour of the psychological component. All the THs interviewed were strongly against such recommendation as

all aspects of traditional healing were seen as interlinked. In order, therefore, for collaboration to occur, a way of regulating the traditional health care sector, including its herbal medications, ought to be developed. There is no doubt that the THs are welcoming of such regulations, as they acknowledge the existence of unscrupulous practitioners, and are supportive of government interventions in this regard. The issue, however, is that attempts at regulation do not include THs and a need for government to consult on the ground was strongly expressed by the THs.

Most of the healers were unaware that official policies with regard to TM even existed. Furthermore, while the benefits of traditional healing were recognized as early as 1994 in the ANC National Health Plan, and are more explicit in some of the other policies, most of the documents call for the restructuring of TM in a way that suits the medical establishment and pay little regard to what THs themselves would advocate. It is clear from the policy analysis that no more than lip service has been paid to the institutionalization and recognition of TM on behalf of the government. This has undermined collaborative efforts between allopathic and traditional health practitioners and there is a need, therefore, for appropriate policies on TM to be developed through a consultative process with THs, and for the implementation of such to follow if collaboration is to occur.

The success of the Implementation Plan for the Draft Policy that is to be established by the Department of Health will therefore depend on whether THs are consulted in its development. Furthermore, while most of the healers were supportive of further training and education the effectiveness of such could be enhanced if mutual exchange of knowledge was encouraged on a longer-term basis and if monitoring and evaluation of such initiatives took place. This might be one of the reasons why collaborative projects have not succeeded, as they have been one sided and have lacked the necessary follow up. However, if this proposed type of training was to occur this would facilitate the realization of meaningful collaboration.

The issue of further education and training was also addressed with regard to prevention - an area in which THs could fulfill an even greater role than they are currently playing. It is obvious that THs are supportive of condom use as well as further training in prevention but, once again, only if accompanied by the necessary ongoing monitoring and implementation. This demonstrates that many of the factors

identified by the doctors as potential obstacles to collaboration, such as the anti-biomedical stance on behalf of THs, are based on outdated information.

It is evident from this study that THs do not hold the view that biomedicine has nothing to contribute and that working with medical doctors is not in their interest. This finding, therefore, suggests that some of the obstacles to collaboration could be overcome if initiatives on behalf of the medical establishment were focused more on meaningful engagement with the THs and incorporation of healers in policy development as well as affective monitoring and evaluation of collaborative efforts.

One area, however, of considerable concern is the denial of negative interactions between ARVs and TM by some THs, as well as the continuing belief held by some of them that HIV/AIDS can be cured. There have been documented cases of some herbal remedies interfering with the efficacy of ARV treatment but despite this some healers continue to insist that simultaneous intake of TM and ARVs is in no way problematic. However, as discussed earlier perhaps through the appropriate type of educational endeavors THs will develop a greater understanding of the harmful impacts of some of their medications and this contentious issue will be adequately addressed.

Another problematic issue is that of personalized medicine, as a characteristic of TM, and the standards of efficacy that differ to those of biomedicine, as TM is not in a position to meet these same standards. This further demonstrates the power relations between the two paradigms, the devaluation of alternative health care knowledge as well the hierarchical nature of medicine which constitutes a clear barrier to any sort of collaboration. Notwithstanding, it was acknowledged by one of the doctors that even biomedicine is beginning to assess the effectiveness of personalized medicine and therefore the question that needs to be asked is whether it is possible for biomedicine to move towards different methods of testing efficacy. Perhaps if communication and interaction between the two paradigms is initiated, solutions will be found.

Although, these problematic issues were identified in the study as potential obstacles and there is no doubt that some of them will continue to exist, this does not mean that some degree of collaboration cannot occur in certain areas. In addition, despite some

resistance that will undoubtedly follow any calls for collaboration, the possibility that it can occur should not be disregarded.

What has been demonstrated, and of great importance is that although the doctors were under the impression that THs do not favour collaboration, all the THs interviewed were in fact welcoming of collaborative efforts between the two sectors. The doctors' view that the THs who are accessible are the ones who choose to be seen may be correct and perhaps the THs I was eventually able to interview were the ones who chose to be interviewed, and hence more open to 'western' perceptions. Perhaps the views expressed by these THs with whom I had contact are not representative of the majority, and just as there are doctors who are completely against collaboration so it would be fallacious to assume that there are no THs who do not share similar views. However, it is certainly clear that there are THs who are supportive of collaboration between the two sectors and it is with these healers, and with those doctors who are also more open to collaboration that the initiatives should begin, as occurred in Valley Trust. However, the others should not be neglected but, as discussed above, perhaps through initially 'forced' communication and interaction, views on both sides will begin to change.

It can therefore be concluded that while engagement between the two sectors may not result in collaboration on every level, it would certainly enlighten both sides to that of the other and agreements would most likely be met in order for a more collaborative environment to exist. Collaboration between these two health care paradigms does not refer to the complete integration of the two systems but rather the acknowledgement of the respective value of each in order to strengthen the areas of compatibility while at the same time accepting the disjuncture between the two.

CONCLUSIONS AND RECOMMENDATIONS

This study has addressed the need for collaboration between the allopathic and traditional health care sectors and has explored the obstacles that are preventing this from occurring. While it is clear that many differences exist between the two paradigms, especially with regard to views on HIV/AIDS, it has been shown that some of these differences have been over-estimated. Therefore, there do exist opportunities for collaboration to occur between the two sectors. This, however, will

only materialize if two conditions are met. The first is the regulation of the traditional health care sector and the second is the further training and education of THs. These two prerequisites, however, will only be met if THs are involved in the development of regulation policies as well as if a knowledge sharing system is established.

With regard to involvement of THs within policy development, the onus is on government to establish consultative process in order to develop appropriate regulatory policies. While the Draft Policy provides a useful starting point, the necessary Implementation Plan must be developed through a consultative process whereby THs are included.

The further training of THs must occur through the use of workshops whereby THs as well as medical doctors exchange information with one in order to facilitate an environment of mutual learning. It must be compulsory for both healers and doctors to attend these workshops and to communicate with one another. Following this, ongoing communication between the two must be fostered, either through one on one contact or through regular workshops. It is doubtful that this type of interaction will occur organically and therefore government must play a role here in making it mandatory. In this way, although interaction will initially be forced, it will result in the shedding of myths of traditional healing and will, hopefully, cause some of the views, on behalf of both paradigms towards the other, to change for the better.

Collaboration will therefore initially only refer to the increase in communication between both sectors. However, it is possible that through such communication further collaborative efforts will be developed. The proposal in the Draft Policy of both healers and doctors working from a shared institution does not seem likely but a system of cross referral should eventually be established between doctors and healers who are in constant communication with the one other. Furthermore, THs should be included in prevention strategies and supplied with the necessary tools to address this area effectively.

Indeed, even if meaningful communication is established between the two sectors, areas of disagreement will prevail, one of which is the standards of efficacy of treatments. However, if mutual respect is genuinely developed from this proposed communication then it would be possible to eventually agree to disagree but to move

forward in areas of potential collaboration. This will demand that both sides move beyond their prospective paradigms of truth accept that one form of knowledge cannot be supported over another.

Medical and health care pluralism refers to the co-existence of different healing systems based on completely different worldviews and it is therefore unrealistic to expect that full collaboration would be able to occur between any two of these different healing systems. However, collaboration in certain areas in this regard essentially depends on eradicating the dominance of the medical establishment and elevating the traditional health care sector so that a sense of equity may emerge. It is my belief that through genuine communication between the two paradigms, this may be possible and may ultimately pave the way for further meaningful collaborative efforts to occur.

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